Supreme Court, U.S.
FILED

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No.

IN THE

Supreme Court of the United States

JOHN A. RULLÁN, SECRETARY
OF THE PUERTO RICO DEPARTMENT
OF HEALTH, ET AL., PETITIONER

v.

CARLOS MORALES FELICIANO ET AL.,

PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

The intervention of this Court is invoked to set aside, under general equity principles and the 1996 Prison Litigation Reform Act ("PLRA"), all relief mandating the transfer and/or privatization of the medical and mental health services now provided by the Commonwealth of Puerto Rico through its Department of Health's ("DOH") Correctional Health Program ("CHP"). Through enactment of the PLRA, Congress sought to halt the micro-management of state prisons by the federal judiciary. The enactment of the PLRA was necessary because, through the exercise of equity powers in civil rights prison litigation, federal courts had become involved in policy-making and in day-to-day administration of state correctional systems.

In the instant case, the second oldest active institutional prison conditions case in the nation, the District Court, and the First Circuit in affirming, have kept in place relief that forces the Commonwealth of Puerto Rico to surrender the responsibility to render health care services to its inmates to a private corporation. The proposition that federal courts can force upon a state a privatization remedy, particularly in the prison conditions litigation context, is contrary both to the holdings of this Court that require extreme caution when federal courts dictate non traditional injunctive relief and to the stringent requirements set forth by Congress in the PLRA to prevent federal courts from turning into policy-makers and administrators of state correctional systems. Furthermore, the interpretations given in this case to the PRLA's dispositions depart radically from the literal meaning of the statute and the congressional

intent behind it. The questions presented, therefore, are:

1. Is court-enjoined privatization of a traditional state government operational area, in this case the rendering of health services to inmates by the Commonwealth of Puerto Rico, a valid exercise of federal equitable powers and an available relief under the 1996 PLRA to address findings of constitutional wrongdoing in the rendering of services to the inmate population?

2. Does 18 U.S.C. sec. 3626(b), the PRLA termination procedure, apply to prospective relief adopted after the enactment of the PLRA that does not have the necessary statutory findings, or does 18 U.S.C. sec. 3626(a) operate instead to render such relief a nullity?

3. In a termination procedure under the PLRA, what is the specific scope of the court's inquiry and how is it to be conducted, particularly in terms of the legal significance that is to be attributed to a consent agreement submitted by the parties, which party bears the burden of proof, and whether the district court must allow discovery and presentation of evidence on the adequacy under the PLRA of the particular relief as to which termination is sought?

PARTIES TO THE PROCEEDINGS

Plaintiffs

Carlos Morales Feliciano, *Individually and as a representative of the entire class of prisoners in the custody if the Correctional Administration of the Commonwealth of Puerto Rico.*

Defendants

Sila M. Calderón
Miguel A. Pereira
John A. Rullán

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JURISDICTION

The United States Court of Appeals for the First Circuit entered its judgment on August 6, 2004. The appellate jurisdiction of the court was invoked pursuant to 28 U.S.C. §1292(a)(1). The certiorari jurisdiction of this Honorable Court is invoked pursuant to 28 U.S.C. §1254. The considerations governing review on certiorari clearly warrant the exercise of this Court's discretion in addressing the three questions presented herein. Rule 10 of the Supreme Court Rules.

As to question number one, in ruling that court-mandated privatization is a valid exercise of federal equitable powers and an available relief under the 1996 PLRA to address findings of constitutional wrongdoing in the rendering of services to the inmate population, the First Circuit has decided an important question of federal law equity jurisdiction that has not been directly addressed by this Court, but which should be settled at this juncture due to its magnitude. The issue presents a compelling question of national importance because the policy decision on whether to privatize or not a state governmental services area has until now been the exclusive province of the states, not subject to federal judiciary intromission. In addition, the challenged decision is contrary to this court's precedent as set forth in the 1999 *Grupo Mexicano* case, or at the very least requires this Court to squarely define, clarify and differentiate on how the inquiry as to whether a particular relief was historically available in 1789 (passing of the Judiciary Act) is to be made and on the additional limits imposed to equity jurisdiction that the passing of the Eleventh Amendment implied. Furthermore, the district court's ruling is contrary to

this Court's proposition that intervention in the relationship between the states and their political subdivisions is an area that has been barred to the federal courts absent the clearest and most articulated Congressional intent. *Nixon* 124 S. Ct. at 1563-1564 (2004), *Gregory v. Ashcroft* 501 US 452, 460 (1991). It also appears to be contrary to *Lewis v. Casey*, 518 U.S. 343, 362-363 (1996), where this court cautioned that a federal court has to respect the limits on its role by not engaging itself into prison administration and instead must allow prison administrators to exercise wide discretion within the bounds of constitutional requirements. The challenged decision also provides an ideal framework for this Court to define whether mandatory privatization is or not an available post-PLRA relief alternative for courts to address inmate conditions problems, particularly in a context where the statutory intent to curb the court's intervention with day-to-day prison affairs is evident. The First Circuit's ruling that this argument was waived because it was not presented at the district court level is also in direct conflict with this Court's rulings that subject matter jurisdiction arguments cannot be waived and can be thus raised for the first time at any stage of the proceedings.

As to question number two, the First Circuit's ruling that prospective relief adopted after the enactment of the PLRA that does not have the necessary statutory findings can be in particular circumstances facially valid and thus that it is subject to termination is directly contrary to rulings made by other circuits. Opinions by other circuits appear to support the proposition that a federal district court cannot validly issue such relief after the 1996 PLRA

enactment, and that the PLRA's termination proceeding only applies to pre-PLRA orders and those issued after its enactment that have the required PLRA findings.[1] The First Circuit's ruling also decides an important question of federal law on strict statutory interpretation of a fairly recent statute, the PLRA. The matter has not been directly addressed by this Court, but should be settled at this time to guide lower courts in their future judicial undertakings. The instant

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[1] See, e.g., *Harvey v. Schoen* 245 F3d 718, 720 (8th Cir. 2001) ("Before approving prospective relief a court must find that the relief is narrowly drawn, ...18 USC §3626(a)(1)(A). Any prospective relief ordered in a civil action with respect to prison conditions on or before the statute's April 26, 1996 enactment date is terminable upon motion of a defendant... §3626(b)(2)); *Castillo v. Cameron County, Texas* 238 F.3d 339, 356 (5th Cir. 2001) (While subsection (a) is applicable to relief entered after the enactment of the PLRA, it is not binding upon injunctions existing at the time of the enactment of the PLRA which are merely terminable under subsection (b)); *Benjamin v. Fraser* 3443 F3d 35, 48 (3rd Cir. 2003) (the PLRA expressly requires that prospective relief which pre-exists its enactment be terminated pursuant to §3626(b)); *Hallet v. Morgan* 296 F3d 732, 743 (9th Cir. 2002) (notwithstanding that a judgment finding that unconstitutional conditions prevailed within a prison, the court could not extend its jurisdiction absent a current and on-going constitutional violation as required by 18 USC §3626(a)); *Gilmore v. People of the State of California* 220 F3d 987, 998-1000, and 1006 (9th Cir. 2000) (Subsection (a) of section 3626 applies to a grant of prospective relief, while if the relief had already been granted subsection (b) applies); *Oluwa v. Gomez* 1333 F3d 1237, 1239-1240 (9th Cir. 1998) (relief sought before enactment of the PLRA, but issued afterwards must comply with the requisite findings); and *Alloway v. Hodge* 72 Fed. Appx. 812, 816 (10th Cir. 2003) (Congress' purpose in requiring the findings set forth in §3626 (a) is that the district court make these findings explicit to demonstrate that the court considered the appropriate factors in a timely manner).

case provides the ideal framework for this question to be settled at this juncture.

As to question number three, the decision as to which review is sought entails an understanding of the PLRA's termination provision and the procedures thereunder that appears contrary to the statutory language and the legislative intent. In its PLRA rulings, the First Circuit has sanctioned a radical departure from the accepted and usual course of a PLRA termination judicial proceeding, thus creating confusion as to the manner in which such proceedings are to be conducted. The instant case provides an ideal framework for this Court to settle once and for all a compelling question of national importance as to how are PLRA termination proceedings to be conducted, who bears the evidentiary burden, the effect if any of prior consent agreements on the final ruling on termination and whether the adequacy under the PLRA of the Court's intended relief is an appropriate area of inquiry and evidence presentation in termination proceedings. It should also be noted that, in affirming the district court's placement of the evidentiary burden on petitioner, the First Circuit's opinion is in direct conflict with precedent by the Fifth Circuit on exactly the same issue. See *Guajardo v. Texas Department of Criminal Justice* 363 F3d 392, 395-396 (5th Cir. 2004) (After the party moving for termination under §3626(b) establishes the requisite passage of time, the burden shifts to the party opposing termination to prove that unconstitutional conditions prevail on a system-wide basis; and that the relief in place meets the narrowness-necessity-intrusiveness requirements). Because courts of appeals are split on

this issue, this Court is compelled to establish uniform guidelines over such an important matter.

RELEVANT PROVISIONS INVOLVED

See Appendix

STATEMENT

The twenty-five (25) year long history of this case may be summarized as follows: In early 1979 this class action was filed against various public officers pursuant to 42 U.S.C Sec. 1983. Plaintiffs' class is composed of all inmates incarcerated under the custody of the Administration of Corrections ("AOC"). Some of the defendants are the Governor of the Commonwealth of Puerto Rico, the AOC, which is the governmental agency in charge and with custody of pretrial and convicted inmates, the members of the Parole Board and herein petitioner, John Rullán M.D., Secretary of the Department of Health ("DOH") of the Commonwealth of Puerto Rico. In their complaint, the inmates alleged to be subjected to unconstitutional conditions of confinement. This case covers practically every area of prison operation and administration, the defendants being subjected to a myriad of orders issued by the court in connection thereto.

On January 3, 1979, the district court entered a preliminary injunction through which the defendants were to address and solve some emergent problems affecting the inmates, the overcrowding and the inadequacy of the medical and mental health services being the most outstanding according to the court's

appreciation. *Morales Feliciano v. Romero Barceló*, 497 F. Supp. 14 (1980).

The next significant order was issued on March 21, 1986, wherein the court evaluated defendants' compliance with its six year old preliminary injunction, found that defendants had failed to comply and appointed a Court Monitor pursuant to Rule 53 of the Fed. R. Of Civ. P., whose duties and powers were to evaluate all the implicated areas in the operation of the AOC and recommend the court remedies thereto. *Morales Feliciano v. Romero Barceló*, 672 F.Supp. 591 (D.P.R. 1986).

In 1990, the district court approved and ordered the implementation of the Medical and Mental Health Care Plans ("MMHC Plans") which was recognized by the district court to be the result of a thoughtful consensual effort by the parties that embodies a synthesis of the professional judgment and input of the Commonwealth defendants. *Morales Feliciano v. Roselló González*, 13 F. Supp.2d. 151, 157-58 (D.P.R. 1998). The MMHC Plans obliged *–inter alia-* the transfer of the primary responsibility to provide medical and mental health services to inmates from the AOC to the DOH. The DOH created the Correctional Health Program ("CHP") as the entity in charge to provide said services.

On January 22, 1996, the district court issued a partial final judgment whereby it made the MMHC plans the final relief as to the medical and mental health area. (This order went unpublished). Thereafter, on March 10, 1997, the district court appointed the former monitor in the case, Vince M. Nathan, as an expert

witness to prepare a report that would update the record of the case as to the state of compliance with the MMHC Plans. Accordingly, Mr. Nathan found that the CHP of the DOH suffered from bureaucratic and administrative problems that compromised its ability to develop a correctional health care system capable to meet the constitutional standards and recommended the appointment of a receiver. On August 18, 1997, evidentiary hearings ensued with respect to Mr. Nathan's recommendation. During the course of the hearings, the parties filed a Joint Stipulation proposing that the government privatize the delivery of correctional health services through the creation by the defendants of a not-for-profit corporation in order to achieve compliance with the MMHC Plans.

On May 18, 1998, the Court issued its opinion and order with respect to the Nathan Report, *Morales Feliciano v. Rosselló González,* 13 F.Supp.2d 151 (D.P.R. 1998) [App. at 89a - 251a]. While the Court found pervasive violations of the MMHC Plans, it declined to appoint a receivership or adopt the privatization proposal submitted by the parties. *Id.*, at 212. The Court did not explicitly adopt the privatization proposal submitted by the parties; instead, it ordered the defendants to implement supplemental relief, suggested by the parties in their Joint Motion.

Notwithstanding the failure of the district court to adopt the privatization proposal submitted by the parties as prospective equitable relief, said Order of May 18, 1998 has retroactively been treated by both the District Court and the First Circuit as the judicial fountainhead adopting the privatization as a judicial

remedy. See *Morales Feliciano v. Rullán*, 303 F.3rd 1, 4 (1st Cir. 2002) and *Morales Feliciano v. Rullán)*, [App. at 261a. - 279a.]

On October 1, 2003, herein petitioner Secretary of Health, filed a motion to vacate or terminate the privatization relief supposedly adopted in the aforesaid May 18, 1998 Order, pursuant to the terms of the PLRA. Evidentiary hearings on the motion ensued on November 4th, 2003. On January 26, 2004, the district court issued its Opinion and Order whereby, *inter alia*, it denied petitioner's motion under the PLRA. The district court recognized in its opinion that the Commonwealth has made significant improvements in the rendering of health services to inmates since the 1998 order as to which termination was sought, but still found that the privatization remedy remained necessary. [App. at 34a – 88a] Subsequently, petitioner filed a timely appeal pursuant to the terms set forth in 28 U.S.C. § 1292(a)(1). On August 6, 2004, the Court of Appeals issued the Order petitioner is seeking review of. [App. at 1a – 33a].

REASONS FOR GRANTING THE PETITION

-QUESTION NUMBER ONE

The mandatory privatization order at issue herein constitutes an extralimitation of the district court's equittable powers and is contrary to both the Eleventh Amendment and the PLRA

The exercise of equity power by a federal court has limitations. As stated by this Court in *Grupo Mexicano*

de Desarrollo S.A. v. Alliance Bond Fund, Inc.[2], one such limitation is that, for an injunctive relief to be valid, it had to be historically available at the time when the Judiciary Act was enacted (1789.) The injunctive relief questioned in *Grupo Mexicano* was characterized as a "nuclear weapon" of the law that went well beyond federal judiciary equity powers, a formidable power that only Congress could exercise by legislation in our democratic system.

The remedy that the district court intends to impose here through its equity jurisdiction, an injunctive relief to force the Commonwealth of Puerto Rico to privatize an operational corrections area (the rendering of health services to the inmates), is clearly beyond the federal court's equity powers. Applying this Court's reasoning, for said exercise of power to be valid in equity, it must have been historically available at the time the Judiciary Act was enacted (1789). Even privatization when a State voluntarily wants to engage in such a practice is a fairly recent endeavor[3], and thus there appears to be no reasonable basis whatsoever to assert that court-imposed privatization of a rendering of services activity that ordinarily befalls in State governments was "historically available" in 1789.

In addressing this issue, the First Circuit basically concluded that the privatization order constitutes a classical mandatory injunction, and that classical

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[2] 527 U.S. 308, 332-33 (1999)

[3] Privatization as an alternative to governmental rendering of services apparently commenced in England during the 1970's. See, Bornstein M., Comparative Economic Systems, Models and Cases, 7th Ed. Burr Ridge, Irwin, Illinois, at p. 120 (1994).

injunctions have been generally available since the *Judiciary Act* was enacted as an alternative to address constitutional maladies[4]. For the First Circuit, the privatization order here at issue is equal in nature to a "garden-variety mandatory injunction."

It is not. Privatization of governmental services, in truth a public administration policy rather than a specific relief, clearly reaches beyond the scope of any mandatory or classical injunction. A classical injunction requires a defendant to perform a given task based on a binding legal principle, which the court seeks to enforce through its equity-enabled tutelage of the interests in conflict. A classical injunction would require that the state design and maintain a health care system that aligns with the current constitutional understanding

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[4]The First Circuit also concluded that, because this issue was not raised before the district court and does not fall under the plain error doctrine, defendant/petitioner waived his right to raise it on appeal. In finding so, the First Circuit radically departed from the settled line of jurisprudence stating that lack of subject matter jurisdiction arguments such as those brought here cannot be waived, and thus can be raised at any time, even for the first time on appeal. See Wright & Miller's Federal Practice and Procedure; 5C Fed. Prac. & Proc. Civ.3d § 1393; *Ford Motor Co. v. Dept. Of Treasury of the State of Indiana* 323 US 459 (1945); *Pennhurst State School & Hosp. v. Halderman* 465 US 89, 99 at n.8 (1984); *Morris v. Gilmer* 129 US 315, 325-26 (1889) *and López v. Arraras* 606 F.2d 347, 350 (1st Cir. 1979), *Louisville & N.R. Co. v. Mottley* 211 U.S. 149, 152, 29 S.Ct. 42, 43 (1908). The inquiry on whether or not Congress, by legislating the 1897 Judiciary Act, granted federal courts the power in equity to enforce a privatization relief goes to the core of federal subject matter jurisdiction, as it cannot be reasonably argued that, through waiver or otherwise, a litigant could vest on a federal court a power to act in equity that goes beyond historically recognized federal judiciary equity powers.

and meaning of the Eighth Amendment, mandatory privatization undoubtedly requires a wider swath of conduct because the court does not only flesh a legal concept that binds the parties, but also engages in the formulation of policy and principles that would necessarily guide the corporation which results from the privatization order. This broad judiciary intrusion and complete stripping of administrative authority to vest it on a private party of the court's choosing cannot be fairly implied as a part of the equity powers granted by Congress in 1789. Moreover, as discussed next, the court cannot enforce this particular remedy without infringing on the Commonwealth's right to exclusively engage in the enunciation of the state policy which shall regulate inmate health care.

To support its ruling, the First Circuit cited cases in which this Court has upheld different innovative applications of the district court's equity powers, particularly case law developed during the attempts made at the federal judiciary level to compel desegregation of public schooling. Innovative as the remedies sustained therein may be, these cases only enjoined the states from acting in a particular manner, and compelled their acting in another, so that desegregation was finally achieved. None of these cases sought to strip the states from their sovereign prerogatives as providers of free public schooling. The plenary authority of state agencies is recognized, and broad federal judicial intervention is only held to be warranted when the local authorities are in default. *Swann v. Charlotte-Mecklenburg Bd. Of Education* 402 US 1, 14 (1971).

If any of the courts that handled these cases had stripped the state government completely of its authority to deliver school busing services and compromised the state government budget to fund a private endeavor created under the court's tutelage to supplant the state government in the rendering of school busing services, relief thus issued would not have passed constitutional muster. If the district court in the instant case had issued innovative relief directed to streamline the rendering of services by the Commonwealth thus leaving to the Commonwealth the policy decision on how to comply with the court's mandate, the analogy with the school busing cases would be reasonable. But in issuing the privatization order here in question the district court went well beyond a permissible innovative exercise of its equity jurisdiction to supplant the Commonwealth's no privatization public policy for the court's own vision on how the services should be administered, and thus the First Circuit's analogy that ends with the "garden-variety mandatory injunction" wording is untenable. Moreover, that the herein challenged exercise of equity powers was made in the corrections context, an area in which Congress has recently legislated specifically to avoid micro-management by courts, further distanciates the relief entered in this case from that entered in the school busing cases.

Besides the unsurmountable jurisdictional hurdle that the historical unavailability in equity of a relief such as mandatory privatization to address constitutional maladies poses, the recognition of the states' sovereign immunity through the approval of the Eleventh Amendment to the Constitution of the United States clearly operates as a further limitation to the

enforcement of such equitable power. The Eleventh Amendment was passed in 1798. It confirms that "the fundamental principle of sovereign immunity limits the grant of judicial authority in Art. III." *Green v. Mansour* 474 U.S. 64, 68 (1985). "[T]he doctrine's central purpose is to "accord the States the respect owed them as" joint sovereigns" *Federal Maritime Com'n v. South Carolina State Ports Authority* 535 U.S. 743, 765 (2002).

States are unbound in their capacity and ability to define the entities through which they will administrate their own affairs and to endow these entities with the necessary powers and prerogatives to execute the delegated functions. *Nixon v. Missouri Municipal League* 124 S. Ct. 1555, 1561-1562 (2004) (preemption provision of the Telecommunications Act could not endow municipalities with the prerogative of engaging in telecommunications services, nor extirpate from the states the ability to grant or withdraw authority to that effect). Intervention in the relationship between the states and their political subdivisions is an area that has been barred to the federal courts absent the clearest and most articulated Congressional intent. *Nixon* 124 S. Ct. at 1563-1564, *Gregory v. Ashcroft* 501 US 452, 460 (1991). The power to define the entities through which the states will render governmental services and execute their political functions and prerogatives must be considered as an integral part of the states' sovereign immunity. Inasmuch as the Eleventh Amendment bars the federal judiciary from entertaining suits to which the states have not consented, the federal judiciary is also barred from decreeing a remedy that impinges on the states' ability to limn the fundamental characteristics of the entities

that they use to discharge their political functions. The decision on whether to privatize a traditional state governmental service area is vested on the state, not on the federal judiciary.

Going beyond the general equity powers granted by the 1789 Judiciary Act and the federalism limitation on such powers embodied in the 1798 Eleventh Amendment, the only possible sources from which to derive the clear and specific Congressional intent required to give federal courts the power to issue an order such as the privatization mandate questioned herein are 42 USCA sec. 1983 (1871) and the PLRA (1996).

In enacting section 1983, Congress saw fit that a federal court be empowered with the equitable right to halt the continuing violation of federal constitutional rights by state officers. *Mitchum v. Foster* 407 US 225, 242-243 (1972). "But neither logic, the circumstances surrounding the adoption of the Fourteenth Amendment, nor the legislative history of the 1871 Act [Section 1983] compels, or even warrants, a leap from this proposition to the conclusion that Congress intended by the general language of the Act to overturn the constitutionally guaranteed immunity of the several States." *Quern v. Jordan* 440 US 332, 342 (1979). Congress was never empowered to legislate in a positive manner to assure the enjoyment of constitutional rights: the power to do so remained reserved to the states. *see Ex Parte Virginia* 100 US at 346-347; *United States v. Cruikshank* 92 US 542, 551 (1875); *United States v. Cruikshank* 92 US at 543 and 555. Nor can Congress grant the federal judiciary a power to make substantive changes to the political

institutions and structures of the states because it was never endowed to it as part of the Enforcement Clause of the Fourteenth Amendment. *City of Boerne v. Flores* 521 US at 525-526.

The specific limitation of Section 1983 to state officers and its remedial rather than substantive character eviscerate any notion that states themselves can be forced to respond to a violation of constitutional rights by relinquishing any of their fundamental sovereign prerogatives. Here, the privatization initiative provides more than simple remedial relief from the extant constitutional violation: the challenged order entails substantive changes to the Commonwealth's political institutions and structures, changes that can only be performed by the Commonwealth itself as part of its sovereign prerogatives. It logically follows that section 1983 either limits even more the general equity powers that may stem from the Judiciary Act due to its remedial nature and by requiring state action for liability to accrue, or at the very least has nothing in its language from which the notion that Congress has empowered federal courts to issue relief such as the one here in question could be reasonably derived.

That leaves the 1996 Prison Litigation Reform Act. The PLRA constitutes an effort by Congress to stop the micro-management of the states' day-to-day correctional affairs by the federal judiciary through the exercise of its equity powers. The PLRA's language and intent not only gives no support whatsoever to the proposition that Congress has empowered federal courts to issue equitable relief such as the one here in question, but directly contradicts it.

Contrary to the damaging precedent set forth by the First Circuit Court's opinion at issue here, the PLRA - as enacted –clearly forbids federal courts from issuing an injunctive relief whereby the privatization of an inherent public function of the local government is set forth as an adequate remedy to a constitutional violation in a prisons' litigation context. Through the enactment of the PLRA and its plain language, Congress - in an unambiguous fashion – explicitly imposed strict limits in the federal court's equitable powers to issue injunctive relief orders to remedy prisoners' constitutional rights' violations in local and state prisons. As set forth throughout some of the relevant PLRA provisions, equitable remedies considered much less narrow and less intrusive than the privatization remedy at issue here, have been restricted if not eliminated under the PLRA.[5]

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[5]Very significantly and in particular, Congress explicitly provides that – *Inter alia*, federal courts are no longer empowered to: (1) approve a prospective relief in the absence of full compliance with the requirements set forth in § 3626 (a)(1); (2) order any prospective relief that requires a state official to exceed the authority vested in him or her pursuant to State law or that otherwise violates State Law unless, some conditions are present as set forth specifically in §3626(B); (3) order the construction of prisons or raise taxes. See, §3626(C); (4) enter a prisoner release order unless issued by a three judge panel and in compliance with the requirements set forth under §3626(a)(3); (5) enforce compliance with a consent decree that fails to comply with the aforestated requirements in §3626 (a)(1). See, also, §3626 (c)(1); (6) appoint a Special Master to supervise the remedial phase of the litigation unless it complies with the requirements and duties to be assigned as set forth in § 3626(f).

It all adds up to a single proposition: a federal court's exercise of equity powers cannot extend as far as it has in this case, more so in the corrections context. Here the court imposed the privatization formula to the whole landscape of correctional health-care. In doing so, the court went far beyond its equity powers to tailor a remedy that both clearly infringes the Commonwealth of Puerto Rico's sovereign powers to define the institutions through which health-care are to be afforded to inmates, and runs afoul of the remedial nature of relief entered under Section 1983 and the clear Congressional intent embodied in the PLRA.

-QUESTION NUMBER TWO

The original 1998 order through which the district court supposedly adopted the privatization relief is a nullity under sec. 3626(a) of the PLRA and thus said relief cannot be further extended

Petitioner Rullán's PLRA challenge to the privatization prospective relief envisioned by the district court and affirmed by the First Circuit is premised on two distinct propositions: that the original 1998 privatization relief order is a nullity and thus unenforceable and, in the alternative, that it should be terminated even if deemed *prima facie* valid. The first issue thus posed by petitioner requires from this court that it settle once and for all a crucial question on how section 3626 of the PLRA, a fairly recent legislation of cardinal importance, should be interpreted: if a post-PLRA relief order is issued without the required findings, is it a nullity as per 3626(a) or is it subject to termination as per 3626(b)?

The PLRA of 1996 established the standards to be followed by the courts for the entry and termination of prospective relief ordered, as in here, in civil actions brought to challenge prison conditions. The May 18, 1998 order here in question was issued after the enactment of the PLRA. Inasmuch as it is apparently intended to impose the privatization of the medical and mental health services to the inmates through a private corporation, the order clearly falls within the PLRA's definition of prospective relief. Therefore, the district court was bound to comply with the applicable statutory requirements for entry of prospective relief.

Under the PLRA, any prospective relief ordered by the court to remedy an ongoing violation must be narrowly drawn, must extend no further than necessary to correct the violation and must constitute the least intrusive means necessary to correct the violation. In tailoring the prospective remedy, the court must give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the relief. From a reading of the order issued by the district court in May 18, 1998, it is evident that the court does not state therein any of the findings specifically required by the PLRA to support the entry of prospective relief directed to impose the privatization of the medical and mental health services to the inmates through a private corporation, nor does it address the issue on whether those findings are supported by the record. Thus, the order is null on its face pursuant to the requirements set forth in the PLRA and, consequently, it should have been and must be vacated. See, 18 USCA sec. 3626(a).

The main request made in this case by Petitioner Rullán that the May 18, 1998 order be vacated inasmuch as it is apparently intended to impose the privatization of the medical and mental health services to the inmates through a private corporation because it does not comply with the statutory requirements stated in 18 USCA sec. 3626(a) and is therefore null and void, should not be confused with the request for termination of relief posed by petitioner in the alternative. Although the statute itself is not crystal clear on the matter, the only reasonable reading of its language is that the termination procedure established therein comes into play only when a defendant seeks to terminate or modify relief which was valid at the time it was issued. A prospective relief order issued after the enactment of the PLRA that does not meet the PLRA requirements set forth in 18 USCA sec. 3626(a) is not subject to termination: it is null and unenforceable. On the other hand, prospective relief orders entered before the enactment of the PLRA, or after its enactment but meeting the statutory requisites for validity, can be terminated by a defendant through the termination procedure detailed in the statute.

The only other possible reading of the statute would be that a party seeking to stop enforcement of a prospective relief order issued after the enactment of the PLRA upon an argument that the order does not comply with the requirements of 18 USC sec. 3626 (a) must first request termination from the same court which issued the order under 3626(b) and 3626(c), a filing which would then set in motion the termination procedure set forth therein. Petitioner Rullán very respectfully submits that said reading of sections 3626 (a), 3626 (b) and 3626 (e) is incorrect and defies basic

rules of statutory construction. Section 3626 (a) specifically precludes the grant or approval of a prospective relief order by the district court unless the requirements set forth therein are met ("[t]he court **shall not** grant or approve any prospective relief...") (emphasis supplied). The most reasonable conclusion from this language is that, if a court acts directly against this provision by issuing a prospective relief order without the required findings, the order thus issued is null and void and can be challenged by a defendant as an extra-limitation of powers by the court. In this case, because the court was precluded from issuing the intended privatization prospective relief if it did not make the required findings, the order thus issued is a nullity, and cannot be terminated because it has never been a valid prospective relief order under the PLRA.

In disposing of this argument, the First Circuit draws a distinction between "existing relief orders" and "those not yet issued", to conclude that because "privatization constitutes the status quo and the Secretary advanced no PLRA argument at the time that privatization was originally approved", the 3626 (b) termination procedure controls. This analysis seems flawed on two counts. First, as argued before, the interpretation that 3626(a) only applies to relief not yet obtained would render said subsection useless, because a district court could issue relief without the required findings and keep it in place until the termination procedure established in 3626 (b) is exhausted. In this context, a defendant could not prevent the court from enforcing such relief and the court would have circumvented the mandatory language stated in 3626 (a) (**"shall"**) with no consequence at all. Second, the

premise that the Secretary's predecessor in office, in not challenging contemporaneously the 1998 order that Petitioner now argues is null, somehow made it valid and subject to the 3626 (b) termination procedure runs afoul of the general principle that a null act cannot be given validity, either by waiver or otherwise. In other words, for termination to be warranted, the relief order must be valid to begin with, and the order herein challenged is not. It is thus respectfully submitted that this Honorable Court should settle once and for all that post-PLRA orders that do not contain the required findings are a nullity, cannot be enforced, and are not subject to the 3626 (b) termination procedure but rather must be promptly vacated under 3626 (a) as an extralimitation of the court's powers.

-QUESTION NUMBER THREE

The trial court, and the First Circuit in affirming, comitted serious errors in their interpretation and application of the PLRA's termination procedure, particularly in weighing the existance of a consent agreement in the termination analysis, altering the statutory burden of proof and not allowing evidence on the inadequacy of the imposed privatization relief

Even if it assumed that the 1998 order that supposedly adopted the privatization relief now in question is not a nullity and thus was subject to the PLRA's termination procedure, the district court and the First Circuit in affirming committed serious errors in interpreting the PLRA that must be addressed by this Honorable Court to establish guidelines for future courts to follow on how to deal with this important legislation. To wit, the court weighed heavily in its

analysis and gave judicial significance to the fact that the parties had signed a consent decree which proposed to the court privatization as an alternative; the court shifted the evidenciary burden of proof to require defendant to establish in the negative that there were no constitutional flaws in the rendering of services to inmates; and the court did not allow defendant to discover or present evidence on whether the privatization relief complied with the necessary/ least intrusive/ narrowly tailored PLRA requirements.

It is uncontested that the parties to this case (although petitioner was not in office at the time) indeed filed in 1997 a consent agreement in which they proposed the privatization alternative. The district court in its findings goes time and time again to this consent decree in support of its conclusions. For the district court, the 1997 consent decree practically forestalled any possibility that Petitioner Rullán could be successful in his argument, basically because of the Court's presumption that he was bound to abide by the agreement signed by his predecessor.

It is respectfully submitted that said presumption is flatly wrong. Federal courts have no jurisdiction to enforce as relief what is to be considered a private agreement as per the PLRA. Under the PLRA, parties may enter "into a private settlement agreement that does not comply with the limitations on relief set forth in subsection (a), if the terms of that agreement are not subject to Court enforcement other than the reinstatement of the civil proceeding that the

agreement settled." § 3626(g).[6] The District Court, however, cannot adopt a settlement agreement as a consent decree unless the settlement at issue conforms to the statutory findings. *French v. Duckworth*, 178 F3d. 437 (7th. Cir. 1999) reversed on other grounds *Miller v. French*, 530 U.S. 327 (2000). Thus, the 1997 consent by the parties has no bearing whatsoever on the analysis as to the validity of the original 1998 order or in assessing whether the privatization relief supposedly adopted since 1998 should remain.

Moreover, during the evidentiary hearing held as to petitioner Rullán's request for termination under the PLRA, the district court unwarrantedly shifted the evidentiary burden, placing on petitioner's shoulders the burden of establishing that the MMHC Plans were being complied with and that the health services to inmates rendered by the Commonwealth are constitutionally sound. This error in itself led to an insufficient, tainted and inadequate evidentiary record, and to findings of fact and law that cannot be reasonably sustained under those circumstances. Furthermore, the shifting of the evidentiary burden clearly contravenes the PLRA.

Under the PLRA, a party may file for termination

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[6] The pertinent definitions in the PLRA, §3626(g), mandate that (1) the term "consent decree" means any relief entered by the court that is based in whole or in part upon the consent or acquiescence of the parties but does not include private settlements; (6) the term "private settlement agreement" means an agreement entered into among the parties that is not subject to judicial enforcement other than the reinstatement of the civil proceeding that the Agreement settled.

of a prospective relief order. For termination to be warranted, the relief order has to be facially valid, *supra*. If it is, the termination procedure outlined by Congress in the statute has to be strictly complied with. Under said termination procedure, the Court can rule that the prospective relief order as to which termination is sought should remain, if it finds that the record supports a finding of current and ongoing unconstitutional conditions that warrant the relief and the other statutory requisites are present. There is no question as to burden of proof: the Court can either make a ruling on the record reflecting current conditions or, at its discretion and upon a petition to that effect by the plaintiffs' class, allow plaintiffs an opportunity to present evidence to establish that current and ongoing unconstitutional violations require the relief order to remain.

What the trial court cannot do - but did in this case - is alter the burden of proof to require from the party seeking termination that it supplement the record with evidence that there are no current and ongoing constitutional conditions under the admonition that otherwise the request for termination will be denied. Said judicial course of action is directly contrary to the language and spirit of the PLRA, and puts on its head the termination mechanism tailored by Congress. Under such scenario, a defendant seeking termination of prospective relief would be put in an inferior position than that contemplated by the controlling statute, thus hampering his procedural and substantive rights.

The shifting of burdens' error in this case became even more serious because the district court chose to discredit the expert testimony rendered by petitioner

Rullán's expert on correctional medical, mental and dental health care services and administration, Dr. Robert M. Jones, although no expert testimony to contradict his is on the record. Plaintiffs, if interested in maintaining the privatization remedy, under the PLRA were obliged to bring forth evidence of ongoing unconstitutional conditions by pointing to specific violation instances, and then Petitioner Rullán would have been presumably given the opportunity to assess said evidence with his expert and thus rebut it. Taking into consideration the District Court and Circuit Court's rationale on this matter, the conclusion that the shifting of burdens in this case had a major if not decisive effect on the court's decision not to terminate the privatization relief seems unavoidable.

The District Court and the First Circuit in affirming ~~further~~ erred in their interpretation of the PLRA requirements by failing to examine whether the proposed privatization remedy complies with the PLRA mandates. Under the PLRA, if the court is to provide said relief, the plaintiffs must show and the court must evidence on the record that the proposed privatization is the most necessary, narrow and least intrusive remedy and whether it requires a state official to act contrary to state law. Petitioner Rullán had plenty of legitimate practical and legal reasons to question the adequacy of the privatization relief under the PLRA, but this evidence is not fully on the record of the case because the district court prevented Petitioner from bringing it out in the open at the hearing when it disallowed perfectly appropriate witness and documentary subpoenas of the Correctional Health Services Corporation ("CHSC", the private corporate entity that would render the

medical services to inmates as per the district court's privatization scheme) and its officers to present as evidence.[7] What it is known from the record is that despite over 5 years of existence, after having received $55 million from the Court, while operating "under the court's [ex-parte] supervision", the CHSC is far behind its contemplated schedule, and that to this date, seven years after the 1998 privatization order, the CHSC has not treated a single patient nor cured a common cold.

In ruling against the admissibility of evidence pertaining to the CHSC, the lower court effectively prevented petitioner Rullán from presenting evidence on the record that was extremely relevant to support his proposition that the private corporation relief is not necessary, narrowly tailored nor minimally intrusive as required by the PLRA for it to survive termination. In a case where applicable law specifically requires from the Court that it make the necessary/ narrowness/ minimally intrusive findings regarding the intended relief, the unavoidable conclusion is that the disallowance of evidence directed to establish that said requisites are not present in this case altered the outcome of the case and thus constitutes reversible error and a radical departure from the normal course of a termination proceeding under the PLRA.

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[7]Notwithstanding, the district court recites and the First Circuit repeats in their respective orders as relevant facts some of the achievements and projects supposedly attributable to the CHSC and its undertakings with the court's financial assistance and supervision. Petitioner was not allowed to discover or present evidence on the matters that he proferred as evidence of the inadequacy of the privatization relief and the CHSC as the chosen corporate vehicle for said privatization

CONCLUSION

The decision challenged herein goes into the core of what the exercise of federal equity jurisdiction entails. The district court, with the First Circuit's acquiescence, has forced the petitioner to fully turn over an operational state government sub division that renders services to inmates, the Commonwealth's Correctional Health Program, to a private corporation of the court's choosing. Petitioner respectfully submits that this Court should decide at this juncture whether such a judicial exercise constitutes an extralimitation of federal powers, particularly in the context of prison system administration after the passing by Congress of the 1996 Prison Litigation Reform Act. Petitioner also submits that even if it is somehow assumed that the district court does have the equity power to issue such a nuclear bomb remedy, in this case, it has put the procedure established in the PLRA by Congress on its head by issuing a post PLRA order without the required statutory findings and afterwards by forcing petitioner into a termination proceeding in which he was unwarrantedly ordered to bear the evidenciary burden, was not allowed to present essential evidence to his termination argument, and was made to carry his termination argument to extremes because of the court's interpretation of a consent agreement that has no bearing whatsoever to the PLRA analysis. Under these circumstances, the mandatory privatization order issued by the district court should not be allowed to stand.

For the reasons set forth above, the petition for a writ of *certiorari* should be granted and the judgment below reversed.

Respectfully submitted.

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United States Court of Appeals
For the First Circuit

04-1300

CARLOS MORALES FELICIANO ET AL.,

Plaintiffs, Appellees,

v.

JOHN A. RULLÁN, SECRETARY OF THE PUERTO RICO DEPARTMENT OF HEALTH, ET AL.,

Defendant, Appellant.

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF PUERTO RICO

[Hon. Juan M. Pérez-Giménez, U.S. District Judge]

Before

Selya, Lynch and Lipez,

Circuit Judges.

Carlos A. Del Valle Cruz, with whom Anabelle Rodríguez, Secretary of Justice, Eileen Landrón Guardiola, Eduardo A. Vera Ramírez, and Landrón & Vera, LLP, were on brief, for appellant.

Carlos V. García Gutiérrez, with whom

Alejandra Bird López, Manuel A. Rodríguez Banchs, Ricardo Alfonso García, and Civil Action and Education Corporation were on brief, for appellees.

August 6, 2004

SELYA, Circuit Judge. Like the legendary Phoenix, this class action litigation involving prison conditions in Puerto Rico is seemingly incapable of eternal rest. The iteration now before us focuses on prospective injunctive relief ordered by the district court in 1998 (the centerpiece of which is the proposed privatization of medical and mental health care throughout the correctional system). Despite his predecessor's enthusiastic assent to that arrangement, the Commonwealth's Secretary of Health (the Secretary), acting in his official capacity, sought five years later to vacate or terminate the consent decree embodying that relief.[1] Following an evidentiary hearing, the district court rejected that initiative. Morales Feliciano v. Calderón Serra, 300 F. Supp. 2d 321 (D.P.R. 2004) (Morales IV). The Secretary now attacks this decision on several fronts. He asserts, inter alia, that the court acted ultra vires; that the court's 1998 order was void ab initio for failure to meet the requirements of section 802 of the Prison Litigation Reform Act (PLRA), Pub. L. No. 104-134, 110 Stat. 1321-66, § 802 (1996), codified at 18 U.S.C. § 3626; and that in all events, the order should be terminated because the district court's supportive factfinding was

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[1]We note that a new administration, representing a different political party, took office following the general election held in November of 2000.

clearly erroneous and infected by errors of law. As a fallback, he argues that the district court bungled the evidentiary hearing and that, at a bare minimum, the matter should be remanded for reconsideration. Finding these importunings unpersuasive, we affirm the decision below.

I. BACKGROUND

Given the long and tortuous history of this litigation — two years ago, we acknowledged that "the lore of this case is Byzantine," Morales Feliciano v. Rullán, 303 F.3d 1, 3 (1st Cir. 2002) (Morales III) — we confine our introductory comments to those events that are most directly germane to this appeal. The shelves of any well-stocked law library will satisfy the appetites of readers who hunger for more exegetic detail. See, e.g., Morales III, 303 F.3d 1; Morales Feliciano v. Parole Bd., 887 F.2d 1 (1st Cir. 1989); Morales IV, 300 F. Supp. 2d 321; Morales Feliciano v. Rosselló Gonzalez, 124 F. Supp. 2d 774 (D.P.R. 2000); Morales Feliciano v. Rosselló Gonzalez, 13 F. Supp. 2d 151 (D.P.R. 1998) (Morales II); Morales Feliciano v. Hernandez Colon, 775 F. Supp. 487 (D.P.R. 1991); Morales Feliciano v. Hernandez Colon, 775 F. Supp. 477 (D.P.R. 1991); Morales Feliciano v. Hernandez Colon, 771 F. Supp. 11 (D.P.R. 1991); Morales Feliciano v. Hernandez Colon, 754 F. Supp. 942 (D.P.R. 1991); Morales Feliciano v. Hernandez Colon, 704 F. Supp. 16 (D.P.R. 1988); Morales Feliciano v. Hernandez Colon, 697 F. Supp. 51 (D.P.R. 1988); Morales Feliciano v. Hernandez Colon, 672 F. Supp. 627 (D.P.R. 1987); Morales Feliciano v. Hernandez Colon, 697 F. Supp. 26 (D.P.R. 1986); Morales Feliciano v. Romero Barcelo, 672 F. Supp. 591 (D.P.R. 1986); Morales Feliciano v. Romero Barcelo, 605

F. Supp. 967 (D.P.R. 1985); Morales Feliciano v. Romero Barcelo, 497 F. Supp. 14 (D.P.R. 1979) (Morales I).

In the 1970s, a group of prison inmates initiated a class action alleging "dire shortcomings in virtually every aspect of prisoner confinement" in the Puerto Rican correctional system. Morales III, 303 F.3d at 3. The district court found the plaintiffs likely to succeed on the merits and issued preliminary injunctive relief. Morales I, 497 F. Supp. at 39-41. The defendants made little progress and the district court, in March of 1986, appointed a monitor. See Morales III, 303 F.3d at 3; Morales Feliciano v. Romero Barcelo, 672 F. Supp. at 621. The court charged the monitor with studying various elements of the correctional system and recommending remedial action. With the monitor's assistance, the court became more proactive and issued a torrent of orders, including temporary restrainers and contempt citations. The court thereafter imposed multimillion dollar fines for the most egregious failures to comply with its directives.

In 1990, the court ordered the implementation of medical and mental health care plans recommended by the monitor. These plans transferred the primary responsibility for medical and mental health care in the correctional system from the Administrator of Corrections (the AOC) to the Secretary. The plans also required that the Secretary employ for a minimum of three years a chief health care coordinator (the CHCC) who would bear responsibility for easing the transition and coordinating compliance.

Over time, prison conditions improved. In 1996, the district court entered a partial final judgment that settled several disputed issues and urged attempts at consensus-based compliance efforts as to other issues.

Despite improvements in many areas, the delivery of medical and mental health care lagged behind.

In April of 1997, a court-appointed expert found the existing health care programs incapable of meeting constitutional standards and suggested, as an alternative, the appointment of a receiver. The parties (who, over a quarter of a century, have agreed on little else) unanimously opposed this recommendation. They suggested instead the formation of a private non-profit corporation to provide medical and mental health services to the inmate population. On September 26, 1997, the parties drafted, executed, and filed a stipulation embodying this consensus. Under the terms of the stipulation, a non-profit corporation was to be formed. The corporation would be structured to provide health care services, consistent with the 1990 plan, to all individuals held in institutions operated by the AOC. The stipulation pledged the parties' full cooperation, required the Secretary and the AOC to lay the groundwork for a transition, and offered to subject the process of privatization to the supervision of the district court. Finally, the stipulation memorialized the parties' agreement to engage in further discussions concerning the role and authority of the CHCC.

The district court endorsed the stipulation and, thus, assumed ownership of the privatization plan that had been conceived by the parties. See Morales III, 303 F.3d at 3-4; see also Morales II, 13 F. Supp. 2d at 212-14 (justifying the adoption of the privatization remedy by elaborating on the grave constitutional deficiencies that continued to haunt the existing programs). The order, as it pertains to this appeal, has retained its original substance. The non-profit entity, known as the Correctional Health Services Corporation (the CHSC), has been formed.

The parties and the district court envisioned the CHSC as a key piece of the privatization machinery. Withal, the CHSC was intended as a transitional device rather than as the exclusive provider of inmate health care services in perpetuity. The parties expected that within a few years of its full implementation, the CHSC would compete with private health care providers for contracts to furnish health care services to those persons held in the AOC's custody. This expectation remains in force.

The CHSC has a checkered history. Originally, the parties hoped that it would begin to function as early as July 1, 1998, and become fully operational as a provider of health care to the inmate population by the end of that year. That prediction proved wildly optimistic. Although the district court, using accrued fines, has made substantial funding available to the CHSC — as of the date of the district court's decision, roughly $55,000,000 had been spent on the privatization solution — this monetary infusion has not yet brought the project to fruition. While the CHSC has made substantial progress toward reaching its stated goals, the pace has been much slower than anticipated. To this point, the CHSC has developed an administrative infrastructure, fashioned an impressive set of substantive programs, and constructed needed facilities. As a result, it has begun contributing to the management of payroll, staff assignments, inventory, purchasing, billing, and financing. The CHSC's achievements in formulating substantive programs include the creation of an electronic database for health records, patient tracking, and the keeping of appointments; the design of a telemedicine program to enable remote diagnosis and treatment of psychiatric illnesses; and the training of personnel to maximize the

efficacy of these (and other) programs. The CHSC also has improved the quality of the facilities and equipment dedicated to the provision of inmate health care. In the same vein, it has purchased and installed computers at most of the institutions operated by the AOC. Last — but far from least — it is in the process of developing a new acute care hospital.

Without in any way minimizing either the value or extent of these accomplishments, it is evident that the CHSC has lagged far behind the timetable that its proponents originally envisioned. Part of the reason is that court supervision has made the process cumbersome (for example, lengthy periods of time have been consumed in the submission and approval of budget proposals). Other factors, such as snail's-pace negotiations with outside contractors, false starts, and resistance to change, have contributed to the delay. Though this lag time may have been unavoidable, the fact remains that, to this date, not a single patient has been treated by the CHSC.

On October 1, 2003, the Secretary, emphasizing this protracted period of delay and the mounting costs of completing the necessary infrastructure, filed a motion under the PLRA to vacate or terminate the privatization component of the extant consent decree. The plaintiffs cross-moved to modify the medical and mental health plans by terminating sections of the decree that assigned the primary responsibility for inmate health care to the Secretary. See Morales IV, 300 F. Supp. 2d at 342-43. The cross-motion went unopposed and the district court granted it. Id. at 343.

Following an evidentiary hearing on the main motion, the court found that pervasive and persistent constitutional violations continued to shackle the delivery of health care in Puerto Rico's correctional

system. Id. at 323-31. The court also found that the contemplated relief — privatization — satisfied the requirements of the PLRA. Id. at 331-38. Accordingly, the court upheld the challenged portion of the consent decree and directed the AOC to meet with the plaintiff class and submit a further plan for achieving constitutional compliance. Id. at 344-45. The Secretary now appeals.[2]

II. APPELLATE JURISDICTION

We start by clarifying the extent of our jurisdiction. It is beyond serious question that we have jurisdiction over the main elements of this appeal. See 28 U.S.C. § 1292(a)(1) (conferring jurisdiction over interlocutory orders refusing to terminate injunctions). The Secretary, however, has also attempted to raise a tangential issue. With regard to that issue, appellate jurisdiction is more problematic.

The circumstances are as follows. As part of its ruling below, the district court ordered the AOC to "meet [with the plaintiff class] and file with the Court within forty-five (45) days . . . a plan on how the [AOC] will assume his legal responsibility to provide health care to inmates." Morales IV, 300 F. Supp. 2d at 345. The Secretary asserts that this order, ex proprio vigore, violates the PLRA and contravenes Supreme Court precedent regarding limitations on the power of federal courts to enforce state law against state officers. Pennhurst State Sch. & Hosp. v. Halderman,

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[2]The AOC has not appealed, and the district court's ukase has not been stayed. We are advised that meetings between the AOC and the plaintiffs are proceeding apace.

465 U.S. 89, 117 (1984) ("[A] federal suit against state officials on the basis of state law contravenes the Eleventh Amendment when . . . the relief sought and ordered has an impact directly on the State itself."). We cannot reach the merits of these claims for we have no jurisdiction over them.

This result is largely dictated by the rationale of our decision in a prior phase of this seemingly endless litigation. In Morales III, we ruled that an order that "was within the lower court's reserved power to establish procedures for compliance with the court's earlier decrees" was not immediately appealable. 303 F.3d at 10. That reasoning is apposite here. A necessary correlate of the lower court's duty to supervise the ongoing process of privatization is the power to issue subsidiary orders in aid of that objective. We thus have no jurisdiction to entertain an interlocutory appeal from this portion of the court's decision (or even to consider the plaintiffs' contention that the Secretary lacks standing to register such a protest).[3]

III. THE MERITS

We proceed to examine the remainder of the Secretary's asseverational array. He has loosed a scattershot attack. Only four of his claims are worthy

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[3]With only isthmian exceptions, the courts of appeals are prohibited from exercising pendent appellate jurisdiction. See Swint v. Chambers County Comm'n, 514 U.S. 35, 49-51 (1995); Limone v. Condon, 372 F.3d 39, 51-52 (1st Cir. 2004). The Secretary offers no developed argumentation on this point and, as matters stand, we believe that this case is not a credible candidate for the exercise of pendent appellate jurisdiction.

of extended discussion, namely, (i) that the lower court lacked general equitable power to grant a privatization remedy; (ii) that the PLRA mandates vacation of the 1998 order as void ab initio; (iii) that, after almost five years of wheel-spinning, the PLRA now mandates termination of the prospective relief; and (iv) that the court repeatedly erred in the course of the evidentiary hearing.[4] We address these issues (some of which have subparts) sequentially.

A. General Equitable Powers.

The Secretary's first broadside need not detain us. He posits that the relief ordered here is an invalid exercise of federal equitable power. Because this argument presents a purely legal issue, it engenders de novo review. See Sunshine Dev., Inc. v. FDIC, 33 F.3d 106, 111 (1st Cir. 1994).

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[4]The Secretary makes a fifth argument: that the relief ordered by the district court requires Puerto Rican officials to act in contravention of local law. The district court refused to address this argument on the ground that the Secretary did not sufficiently specify the nature of the alleged violations. That ruling is supportable, and it precludes reliance on the argument here. See Teamsters Union v. Superline Transp. Co., 953 F.2d 17, 21 (1st Cir. 1991) (holding that arguments not squarely raised in the trial court cannot be advanced on appeal). In all events, the Secretary's appellate presentation suffers from the same lack of specificity; he alleges the violations in the most general terms and does not inform us of where in the record we might find any evidence of them. This lack of developed appellate argumentation constitutes an independently sufficient basis for deeming the argument abandoned. See United States v. Zannino, 895 F.2d 1, 17 (1st Cir. 1990) ("It is not enough merely to mention a possible argument in the most skeletal way, leaving the court to do counsel's work, create the ossature for the argument, and put flesh on its bones.").

At the outset, we note that this argument quite likely is by the boards. The Secretary's predecessor in office stipulated to the privatization remedy, and there is no claim that he lacked authority to do so. Normally, that would constitute a waiver, which would prevent the Secretary from making this argument altogether.

Even if the Secretary is not bound by his predecessor's acquiescence — a matter on which we take no view — the Secretary did not present this argument to the district court and attempts to raise it for the first time on appeal. "It is a bedrock rule that when a party has not presented an argument to the district court, [he] may not unveil it in the court of appeals." United States v. Slade, 980 F.2d 27, 30 (1st Cir. 1992). At the least, then, the argument is forfeited.

We nonetheless inquire briefly into the merits, as forfeited arguments (unlike waived arguments) ordinarily warrant review for plain error. Gómez v. Rivera Rodríguez, 344 F.3d 103, 118 (1st Cir. 2003). That type of review "entails four showings: (1) that an error occurred (2) which was clear or obvious and which not only (3) affected the [appellant's] substantial rights, but also (4) seriously impaired the fairness, integrity, or public reputation of judicial proceedings." United States v. Duarte, 246 F.3d 56, 60 (1st Cir. 2001).

The Secretary concedes that injunctions — like this one — that have been issued pursuant to 42 U.S.C. § 1983 are limited only by the court's inherent equitable powers. See, e.g., Giles v. Harris, 189 U.S. 475, 486 (1903) (Holmes, J.). He insists, however, that a federal court's equitable powers are restricted to the remedies that were available in equity in 1789 (at the time of the passage of the First Judiciary Act). This proposition is a correct statement of the law, see Grupo Mexicano de Desarrollo v. Alliance Bond Fund, Inc., 527 U.S. 308,

318-19 (1999), but the Secretary's application of it fails plain error review.

Specifically, the Secretary characterizes privatization as "a fairly recent endeavor" and claims, therefore, that there is no reasonable basis for holding that court-imposed privatization of duties ordinarily ascribed to the government is within the district court's armamentarium. Appellant's Br. at 29. If this crabbed view reflected the state of the law, equitable remedies would be frozen in time and new remedial applications could never be developed to meet contemporary needs. The view, however, is fundamentally at odds with the core principle that equity must evolve over time "in order to meet the requirements of every case, and to satisfy the needs of a progressive social condition in which new primary rights and duties are constantly arising and new kinds of wrongs are constantly committed." Union Pac. Ry. Co. v. Chicago, Rock Island & Pac. Ry. Co., 163 U.S. 564, 601 (1896).

Consistent with this principle, the Supreme Court has made clear that the inquiry into the availability of equitable relief in a particular case focuses upon whether the general manner of relief sought was available at equity in 1789. See Grupo Mexicano, 527 U.S. at 322. This inquiry is informed by a recognition that equity is flexible and that the boundaries of permissible relief are broad. Id. Thus, the relevant question is not whether a specific application of relief was available in 1789, but, rather, whether that general type of relief was available.

In this case, the answer to that question is affirmative. At bottom, the endorsed anodyne — privatization — calls for relief in the nature of a mandatory injunction, and injunctive relief is a classic equitable remedy. Great-West Life & Annuity Ins. Co.

v. Knudson, 534 U.S. 204, 211 n.1 (2002); Mertens v. Hewitt Assocs., 508 U.S. 248, 256 (1993); Griggs v. E.I. Dupont de Nemours & Co., 237 F.3d 371, 384 (4th Cir. 2001). A survey of contemporary applications of this rule supports this conclusion. Courts consistently have upheld relief in equity notwithstanding the fact that the particular remedial application was not available in 1789. School busing orders exemplify this point. See, e.g., Swann v. Charlotte-Mecklenburg Bd. of Educ., 402 U.S. 1, 30 (1971); Morgan v. Kerrigan, 530 F.2d 401, 414-15 (1st Cir. 1976). If the Secretary's argument were sound, all such orders would be beyond the equitable power of a federal court.

The short of it is that a federal district court, faced with pervasive and persistent constitutional violations, has not only the power but also the duty to render a decree that will, insofar as is possible, return matters to a constitutionally acceptable level. While the privatization remedy constitutes extraordinary relief and can be justified in only the most exceptional circumstances, the nature of the remedy is no different than that of a garden-variety mandatory injunction. Seen in this light, we conclude that the district court did not commit plain error in determining that it had the authority to approve and implement a privatization remedy jointly proposed by the parties.

B. Compliance with the PLRA.

In 1996, Congress enacted the PLRA, partially in an effort to curb the involvement of the federal judiciary in day-to-day prison management. See 141 Cong. Rec. 13,319 (1995) (statement of Sen. Abraham); id. at 14,418 (statement of Sen. Hatch). This ambient intent must guide our interpretation of the statutory

text. See Inmates of Suffolk County Jail v. Rouse, 129 F.3d 649, 655 (1st Cir. 1997).

The PLRA establishes standards for the entry and termination of all prospective relief in civil actions challenging prison conditions. See Miller v. French, 530 U.S. 327, 333 (2000). The term "prospective relief" encompasses "all relief other than compensatory monetary damages." 18 U.S.C. § 3626(g)(7). The statute requires that prospective relief "shall extend no further than necessary to correct the violation of the Federal right of a particular plaintiff or plaintiffs." Id. § 3626(a)(1). It further provides that a federal court "shall not grant or approve any prospective relief unless the court finds that such relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right." Id. A party is entitled to immediate termination of any relief that has been granted in the absence of findings as to these criteria. Id. § 3626(b)(2). Conversely, however, prospective relief "shall not terminate if the court makes written findings based on the record that prospective relief [meets the above requirements]." Id. § 3626(b)(3).

This statutory backdrop provides the setting for the Secretary's next challenge to the propriety of the privatization order. This challenge has three foci, each spawned by the PLRA. We deal with them in order.

1. Validity of the 1998 Order. The Secretary first argues that, when originally entered in 1998, the order approving privatization did not meet the PLRA's requirements and, thus, "must be set aside without further consideration." Appellant's Br. at 31. Because the district court did not make the findings specifically

required by the PLRA coincident with the entry of its 1998 order, the Secretary's thesis runs, the order was void ab initio.[5]

The Secretary's thesis hinges on the premise that when prospective relief does not meet the PLRA's requirements at the moment of issuance, the decree is void without reference to the statutory termination procedure. On this premise, the termination procedure applies only to (i) prospective relief entered before the effective date of the PLRA and (ii) prospective relief entered after that date which is accompanied by the requisite narrowness-need-intrusiveness findings. Prospective relief entered after the PLRA's effective date but unaccompanied by narrowness-need-intrusiveness findings is simply void.

There is no textual support for the Secretary's position. He relies on the mandatory language of 18 U.S.C. § 3626(a), which states that "[t]he court shall not grant or approve any prospective relief" in the absence of specific findings. But this subsection sets forth the standard district courts must follow when determining whether prospective relief not yet ordered is permitted

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[5]Although we assume arguendo the correctness of the Secretary's assessment of what transpired in 1998, we note that the district court made a series of contemporaneous written findings, which may well have satisfied the narrowness-need-intrusiveness requirements. See Morales II, 13 F. Supp. 2d at 212 (holding that privatization "is necessary to protect the members of the plaintiff class from cruel and unusual punishment through constitutionally unacceptable health care services," that the remedy "extends no further than is necessary to correct the violation of the Federal rights of members of the plaintiff class," that "such relief is narrowly drawn," and that there "is no less intrusive means to correct the violation of plaintiffs' Federal rights").

by the PLRA. Gilmore v. California, 220 F.3d 987, 999 (9th Cir. 2000) ("If prospective relief has already been granted by a court, § 3626(b) controls."). Here, however, privatization constitutes the status quo (and the Secretary advanced no PLRA-based argument at the time that privatization was originally approved).

The only authority cited by the Secretary — Rouse — does not support his point of view. He asserts that Rouse drew a distinction between orders issued prior to the enactment of the PLRA and those issued subsequent thereto. That is incorrect. Rouse drew a distinction between "existing federal court orders" and those "not yet obtained." 129 F.3d at 654. That distinction contradicts the position that the Secretary advocates in this appeal.

Accordingly, we hold that the procedure limned in 18 U.S.C. § 3626(b) applies to any existing prospective relief, regardless of when that relief was first ordered. See Miller, 530 U.S. at 333 (stating that section 3626(b) applies to "existing injunctions"); Harvey v. Schoen, 245 F.3d 718, 720 (9th Cir. 2001) (holding that prospective relief made "in the absence of the required findings" is immediately terminable "regardless of when ordered"); see also Rouse, 129 F.3d at 654 (suggesting that the termination procedures set forth in section 3626(b) apply to all existing federal court orders).

Since privatization is required by a preexisting court order, the situation is controlled by subsection (b), not subsection (a). See Rouse, 129 F.3d at 654. That makes a significant difference. Nothing in subsection (b) or in its legislative history speaks of vacating consent decrees but only of terminating them. That linguistic shift has practical consequences. "While terminating a consent decree strips it of future potency,

the decree's past puissance is preserved . . . ." Id. at 662.

That gets the grease from the goose. Although 18 U.S.C. § 3626(b) entitles a defendant to termination of existing prospective relief ordered in the absence of the requisite findings, that proviso excepts cases in which the court supportably finds that the particular form of prospective relief remains at the time of the challenge narrowly tailored, necessary, and relatively unintrusive. See id.; see also Guajardo v. Tex. Dep't of Crim. Justice, 363 F.3d 392, 394 (5th Cir. 2004) (per curiam). There is no time limitation present in section 3626(b)(2), nor does its language suggest that it reaches only those orders issued prior to the PLRA's effective date.

To cinch matters, section 3626(b) provides that any order made in the absence of the required findings is subject to "immediate termination." This word choice is significant. See Rouse, 129 F.3d at 662. The verb "terminate" means "to put an end to" or "to end." Black's Law Dictionary 1482 (7th ed., 1999). If Congress had intended that orders issued in the absence of the required findings be void ab initio, it would almost certainly have chosen a phrase such as "void."

To sum up, the PLRA grants the Secretary a right to move for the termination of prospective relief. The PLRA does not, however, confer any right to argue, five years after the fact, that an order should be deemed void ab initio for lack of contemporaneous findings. Therefore, this aspect of the Secretary's challenge founders.

2. The Constitutional Violations. Upon a motion to terminate prospective injunctive relief under the PLRA, a court may continue the relief only if it supportably finds that there are ongoing constitutional

violations. 18 U.S.C. § 3626(b). The district court purposed to make such findings in this instance. See Morales IV, 300 F. Supp. 2d at 323-31, 342. The Secretary counters that the record does not show infirmities sufficient to justify ongoing relief and that the district court's contrary findings are clearly erroneous.

An inquiry into whether current prison conditions constitute an ongoing violation of a federal right "comprises a mixed question of fact and law, the answer to which we review along a degree-of-deference continuum, ranging from plenary review for law-dominated questions to clear-error review for fact-dominated questions." Rouse, 129 F.3d at 661. Here, the question is fact-intensive — the Secretary frontally challenges the lower court's factfinding — so our standard of review is deferential. See id.; see also Dedham Water Co. v. Cumberland Farms Dairy, Inc., 972 F.2d 453, 457 (1st Cir. 1992) (admonishing that appellate courts should respect the trial court's findings of fact unless convinced, after a careful review of the record, that a mistake has been made). If there are two permissible views of the evidence, the factfinder's choice between them must be respected. See Fed. Refin. Co. v. Klock, 352 F.3d 16, 29 (1st Cir. 2003). The lower court's factual findings easily pass muster under this deferential standard.

We have painstakingly reviewed the record and examined the numerous findings of fact, mindful that a trial court generally is considered the most informed interpreter of its own prior rulings and findings. See Rouse, 129 F.3d at 661. In this instance, the court was very careful to update the record and to consider the ways in which conditions had changed since its original endorsement of the privatization concept. See Morales

IV, 300 F. Supp. 2d at 323-31. The court painted a compelling, record-rooted picture of how and in what respects health care for inmates in Puerto Rican prisons remains constitutionally deficient. See id. On this grim record, it is simply implausible to suggest that these findings are clearly erroneous.

The district court characterized the denial of medical and mental health services as "massive and systematic." Id. at 324. That characterization seems apt. No useful purpose would be served by rehearsing the court's findings in minute detail. We offer instead a few of the more glaring examples. As of 2003, one-fourth of all inmates who requested sick call did not get it; only 55% of all ambulatory care appointments actually took place; only 49% of specialist consultations deemed necessary for serious conditions were arranged; as a rule, medically prescribed diets for inmates were habitually ignored; only 31.3% of inmates who had been diagnosed HIV-positive were receiving treatment; and inmate mortality rates were rising. See id. at 323-31. These are but the tip of a particularly unattractive iceberg. Despite the CHSC's efforts, physical facilities for inmate health care remain inadequate and there is an acute shortage of psychiatric expertise. See id. at 326-27, 331. Basic health care is critical to maintaining a decent quality of life, and Puerto Rico's correctional system is not delivering a constitutionally acceptable level of health care to its captive population.

We acknowledge that in the course of making these findings, the district court largely disregarded the testimony of the Secretary's expert witness as lacking in credibility. Although the Secretary complains bitterly about this rejection, it is hornbook law that matters of credibility are ordinarily for the

court of first instance, not for the appellate court. Laurent v. Ashcroft, 359 F.3d 59, 64 (1st Cir. 2004). Unless the record mandates a contrary finding — and this record most assuredly does not — the court of appeals ought not disturb a trial court's credibility determination. See Anthony v. Sundlun, 952 F.2d 603, 606 (1st Cir. 1991); see also 9A Charles Alan Wright & Arthur R. Miller, Federal Practice & Procedure § 2586 (2d ed. 1994) (collecting cases). Here, moreover, there is much to commend the district court's assessment of the witness's dubious credibility (for example, the witness provided haphazard and inconsistent testimony and, on cross-examination, withdrew or corrected a myriad of statements).

The Secretary accurately observes that some noteworthy advances have been made in the delivery of health care to inmates. He overlooks, however, that notwithstanding these improvements, the district court found substantial deficiencies attendant to virtually every aspect of the inmate health care system. Morales IV, 300 F. Supp. 2d at 324. However laudable the advances may be, the district court's supportable finding that constitutional violations persist suffices to satisfy the requirements of the PLRA and to justify a comprehensive injunctive decree.

To say more on this subject would be supererogatory. We hold, without serious question, that the district court's findings and conclusions about the incidence of continuing constitutional violations are adequately anchored in the record.

3. The Narrowness-Need-Intrusiveness Findings. The PLRA mandates "the termination of extant consent decrees altogether unless the district court makes the specific findings that are necessary to keep a particular decree alive." Rouse, 129 F.3d at 655.

In addition to ongoing constitutional violations, this compendium includes a finding that the ordered relief satisfies the statutory narrowness-need-intrusiveness criteria. See 18 U.S.C. § 3626(b). The district court made such findings here. See Morales IV, 300 F. Supp. 2d at 342. The Secretary argues that the facts of this case, as found, require termination of the decree because the chosen remedy — privatization — does not meet the narrowness, need, and intrusiveness requirements delineated in the PLRA.

Congress plainly intended the PLRA to operate as a mechanism that would decrease federal judicial involvement in prison administration. See Rouse, 129 F.3d at 655. Congress left room, however, for needed injunctive relief. The Secretary's insistence that Congress did not want courts involved in prison administration begs the real question — which is whether a particular set of facts, measured under the statutorily specified criteria, warrants continued judicial involvement. We think that this is a close call in the case at hand, but for the time being, we find supportable the district court's conclusions regarding narrowness, need, and lack of intrusiveness.

The narrowness-need-intrusiveness criteria are, to some extent, self-explicating. The devil is in the details attendant to their application. The application of those criteria is case-specific and must be undertaken in light of both the magnitude of existing constitutional violations and the available remedial alternatives.[6] See,

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[6]We reject out of hand the Secretary's argument that an order to privatize is a per se violation of the narrowness requirement of the PLRA. The narrowness of a remedy necessarily involves a close examination of a particular set of facts and a determination concerning what steps are reasonable to cure the ongoing constitutional violations. Because this will necessarily

e.g., Clement v. Cal. Dep't of Corrections, 364 F.3d 1148, 1153 (9th Cir. 2004). The constitutional violations here are substantial in both scope and degree. They have defied correction for more than two decades. The district court has tried more conventional measures, but found them wanting. It has afforded the Commonwealth ample opportunity to bring preexisting mechanisms up to speed or otherwise to correct the phalanx of problems. It has witnessed the Commonwealth's continued inability to cure the constitutional infirmities plaguing the delivery of health care in the correctional system. This record of abject failure matters in the narrowness-need-intrusiveness inquiry. See Benjamin v. Fraser, 343 F.3d 35, 49 (2d Cir. 2003) (upholding narrowness-need-intrusiveness findings "in light of the district court's finding that the [defendant's] compliance with its remedial responsibilities has been consistently incomplete and inadequate").

The need for continued prospective injunctive relief is patent. The lower court has been dealing with the deficiencies of Puerto Rico's correctional system since 1979, and we acknowledge that the sheer passage of so much time counsels restraint in ordering further extensions of prospective injunctive relief. See, e.g., Spangler v. Pasadena City Bd. of Educ., 611 F.2d 1239, 1241 (9th Cir. 1979). However, the correctional system is sprawling, the problems with which the court has had to grapple are massive, the Commonwealth's acceptance of the need for reforms has ranged from inconsistent to grudging (witness the current state of

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be influenced by a variety of factors, we are wary of adopting ironclad rules.

affairs in which the AOC embraces privatization as the Secretary seeks to dismantle it), and progress has been correspondingly slow. Insofar as health care is concerned, the level of improvement still falls well short of bringing serious violations into constitutional compliance. Morales IV, 300 F. Supp. 2d at 323-31. In some respects, backsliding has occurred. See id. at 324. In light of these facts, we have no difficulty affirming the district court's finding that a need for ongoing injunctive relief exists.

We next consider the district court's findings regarding narrow tailoring and lack of intrusiveness. In 2003, the district court was keenly aware of its duty to ensure that prospective remediation complies with the PLRA's requirements. See Morales IV, 300 F. Supp. 2d at 331. It was, however, faced with a constitutional crisis and only three proposed solutions: turning back the health care clock to reinstate the system that had failed miserably for two decades, placing the system into receivership, or persisting with the plan for privatization (which the parties had conceived and to which they originally had agreed). The status quo ante alternative had proven to be ineffective, and, thus, was undesirable. No one favored the receivership alternative. That left privatization. Against this mise-ên-scéne, we cannot say that the lower court's choice of that alternative was unreasonable.

The Secretary nonetheless argues that privatization is much broader than necessary to forfend against cruel and unusual treatment of inmates. If this were the district court's first attempt at remediation, we quite likely would agree. But the district court has attempted narrower, less intrusive alternatives — and those alternatives have failed to restore the

constitutional balance. For this reason, a more innovative remedy is justifiable. The increased intrusiveness and broader scope of the privatization remedy is a direct response to the unique need created by the Commonwealth's own failure — for more than twenty years — to correct serious constitutional inadequacies. Drastic times call for drastic measures.

The Secretary has one final shot in his sling. He laments that privatization is far behind schedule and has accomplished very little to date. Nevertheless, a great deal of time, effort, and money has been spent in constructing facilities, procuring equipment, creating programs, and building a more responsive infrastructure. Perhaps more important, the CHSC has developed a functional information technology system. Knowledge is power, and that platform seems reasonably likely to contribute measurably to the long-term success of the prison health care system. It provides a means of maintaining accurate records and thus creating accountability. See, e.g., Carol Gentry, Health-Care Firms Face Costly Change, Wall St. J., Jan. 3, 2000, at A3 ("By speeding up the transmission and improving the accuracy of information, health plans should be able to do a better job of monitoring the quality of care."); Laura Landro, Health Care Goes Digital: Doctors and Hospitals Find They Can't Stay Offline Any Longer, Wall St. J., June 10, 2002, at R6 ("There is a clear linkage now between technology and better patient outcomes."). The district court has cultivated this tree patiently and at great expense, and it would be rash for us to insist that it be uprooted just when it shows promise of bearing fruit.

The Secretary's related complaint — that the ineffectiveness of privatization to date defeats the finding of narrowness — is unpersuasive for two

reasons. First, a determination of narrowness requires a court to decide whether ordered relief is tailored to rectify existing constitutional violations. See Cason v. Seckinger, 231 F.3d 777, 784 (11th Cir. 2000) ("The court must make new findings about whether the relief currently complies with the need-narrowness-intrusiveness requirements, given the nature of the current violations."); see also Castillo v. Cameron County, 238 F.3d 339, 354 (5th Cir. 2001). Whether a remedy is capable of successfully ameliorating constitutional violations has no necessary correlation with whether it is narrowly drawn. Narrow relief can be completely ineffectual. See Morales II, 13 F. Supp. 2d at 157-58 (noting the failure of limited injunctive orders to bring the Puerto Rican correctional system into constitutional compliance). That the privatization concept has been slow to come to fruition does nothing to prove that the order is overly broad (or overly intrusive, for that matter).

Second, we think that the PLRA is too blunt an instrument for addressing this concern. As said, the PLRA limits courts to terminating prospective relief. Not every unforseen difficulty in implementing injunctive decrees necessitates the total abandonment of a remedy. It is true that the CHSC has lagged far behind the original schedule and that the corporation has, to date, not accomplished its ultimate goals. It is also true that an ineffective remedy is a cause for concern. In light of the substantial progress that has been made, however, the mere fact that privatization is behind schedule does not convince us that it fails the narrowness-need-intrusiveness test.[7]

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[7]It may well be that modification, or some other more limited adjustment, is appropriate to address such concerns, see

We are well aware that federal oversight of Puerto Rico's correctional system cannot — and should not — last forever. We strongly urge both the district court and the litigants to move the privatization process forward with all practicable speed. For now, however, we conclude, based on the record evidence and the factual findings of the district court, that the privatization order meets the PLRA's requirements. The privatization solution has not yet been put into practice and common sense dictates that it be given a fair chance to work. The order appealed from provides that chance.

C. The Evidentiary Hearing.

The Secretary's fallback position is that the district court committed reversible error in its manner of conducting the evidentiary hearing on the motion to terminate prospective relief. This contention has four branches. All of them are acarpous.

1. Burden of Proof. The Secretary first suggests that the district court impermissibly shifted the burden of proof. This suggestion derives primarily from the court's decision to order the proof by directing the Secretary (rather than the inmate class) to come forward, at the start of the hearing, with his evidence.

It is axiomatic that district courts enjoy wide latitude in matters concerning the ordering of proof and the presentation of evidence. See, e.g., United States v. Holmquist, 36 F.3d 154, 163 (1st Cir. 1994); Elgabri v. Lekas, 964 F.2d 1255, 1260 (1st Cir. 1992); see also Fed. R. Evid. 611(a). We review a trial court's

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Fed. R. Civ. P. 60(b)(5) — but that issue is not before us.

determinations concerning the mode and order of proof for abuse of discretion. Nat'l R.R. Pass. Corp. v. Certain Temporary Easements, 357 F.3d 36, 42 (1st Cir. 2004). We will reverse only if a determination has unfairly prejudiced the complaining party. Id.

The decision to require the Secretary to present his proof first was not an abuse of discretion. In arriving at its decision on the motion to terminate, the court was free to rely on any aspect of the record that tended to shed light on whether constitutional violations persisted. See Laaman v. Warden, N.H. State Prison, 238 F.3d 14, 17-18 (1st Cir. 2001) (noting that the court's familiarity with the record and its receipt of periodic reports may afford it "comprehensive knowledge of whether a prison is, or is not, continuing to violate the consent decree"). At the beginning of the hearing, the court had before it a full evidentiary record, developed over many years, together with a cache of periodic reports as to progress under the consent decree. This plethoric evidence was sufficient, if unrebutted, to support a finding that constitutional violations endured. With this in mind, it was sensible for the court to invite the Secretary to offer evidence to the contrary.

To be sure, a trial court's authority to regulate the order of proof does not include the power to shift the burden of proof. Brown Daltas & Assocs., Inc. v. Gen. Accid. Ins. Co., 48 F.3d 30, 37 (1st Cir. 1995) (reversing a judgment because the trial court erroneously shifted the burden of proof); see also 9 J. Wigmore, Evidence § 2489 (J. Chadbourn ed. 1981). But that is not what happened here: the court's election to hear the Secretary's evidence first in no way betokened reallocation of the burden of proof. In its subsequent review of the evidence, the court said

nothing that indicated any misunderstanding as to where the burden of proof rested. Rather, it supportably determined that the facts presented by the Secretary lacked sufficient probative force to blunt the thrust of the accumulated evidence of record. Morales IV, 300 F. Supp. 2d at 339-40 (relying on the Secretary's own evidence to find continuing constitutional violations). In short, the contention that the lower court impermissibly shifted the burden of proof has no footing in the record.

2. The Agreement Between the Parties. The Secretary next maintains that the district court erred by relying on the existence of a "private agreement" (by private agreement, he means the stipulation that was signed in 1997 by, inter alios, his predecessor in office). Specifically, the Secretary asserts that the fact that there was an agreement between the parties should have had no bearing on the continuing viability of the subsequent order approving privatization (entered in 1998). This assertion overlooks that the so-called private agreement was embodied in a stipulation presented to and adopted by the district court. Upon its adoption, the private agreement became a judicially enforceable consent decree. Frew ex rel. Frew v. Hawkins, 124 S. Ct. 899, 903 (2004) ("A consent decree embodies an agreement of the parties and is also an agreement that the parties desire and expect will be reflected in, and be enforceable as, a judicial decree that is subject to the rules generally applicable to other judgments and decrees." (internal quotation marks omitted)); In re Pearson, 990 F.2d 653, 658 (1st Cir. 1993) (similar).

This is significant because the Secretary's argument blurs the crucial distinction, for PLRA purposes, between private side agreements and consent

decrees. The latter may serve as a vehicle for prospective relief under the PLRA; the former may not. See 18 U.S.C. § 3626(a); see also id. § 3626(c)(1).

In all events, the lower court did not rely impermissibly on the parties' original agreement. Although the court noted the existence of that agreement and scolded the Secretary for trying to renege on it, the holding in Morales IV was in no way premised either on an estoppel or on the fact that the parties previously had agreed to explore a privatization alternative. For these reasons, the Secretary's argument fails.

3. The Exclusion of Evidence. The Secretary also contends that the district court erred in refusing to allow him to introduce evidence as to the narrowness-need-intrusiveness criteria. On this point, as is so often true in litigation, context is decisive.

After the Secretary had presented his evidence as to the existence vel non of continuing constitutional violations, the district court asked him to summarize the evidence that he planned to adduce on the narrowness-need-intrusiveness criteria. The Secretary proceeded to make an offer of proof. Having heard the proffer, the court determined that nothing in it bore directly upon the narrowness of, need for, or potential intrusiveness of the privatization remedy. Consequently, the court rejected the Secretary's offer of proof on relevancy grounds.

We descry no error. In many instances, relevancy boils down to a judgment call. See generally Fed. R. Evid. 401 (deeming evidence relevant if it has "any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence"). Accordingly, district courts enjoy wide

latitude in determining the relevancy vel non of evidence. Laaman, 238 F.3d at 18-19; United States v. Tierney, 760 F.2d 382, 387 (1st Cir. 1985). In this instance, the district court concluded that the offer of proof had no bearing on the appropriateness of the remedy under the PLRA's narrowness-need-intrusiveness criteria. Morales IV, 300 F. Supp. 2d at 337-38. Having reviewed the offer of proof, we find that this ruling was within the realm of the district court's discretion. We explain briefly.

By way of his offer of proof, the Secretary proposed to introduce evidence designed to show the ineffectiveness of the remedy. He began the proffer by alleging generally that the non-profit corporation was not a viable remedy because it had not yet treated a single patient. The district court asked for elaboration, and the Secretary expressed a desire to take discovery on the matter. Morales IV, 300 F. Supp. 2d at 337. When the court refused that untimely request, the only details proffered by the Secretary tended to show that the CHSC was not complying with either the district court orders or Puerto Rico laws, and that it was not ready to begin treating patients. Id. at 338. This is a distinct line of inquiry. See Hadix v. Johnson, 228 F.3d 662, 673 (6th Cir. 2000) (explaining that inquiries into compliance and inquiries into necessity under the PLRA are separate and distinct). As the district court sagely noted, compliance was not at issue in the evidentiary hearing. Morales IV, 300 F. Supp. 2d at 338.

We — like the district court — do not see how the Secretary's offer of proof informs a determination of whether the privatization remedy is a narrowly tailored, relatively unintrusive response to the serious constitutional violations that the district court found

still existed. We note, moreover, that the Secretary has not explained the connection. We thus cannot fault the district court either for the rejection of the offer of proof or for its consequent exclusion of the proffered evidence.

4. Rule 52(c). Finally, the Secretary assigns error to the district court's use of Fed. R. Civ. P. 52(c) as an adjudicative tool. See Morales IV, 300 F. Supp. 2d at 344. Rule 52(c) provides a court conducting a bench trial with a means for issuing a judgment on partial findings. The rule is designed for use when "a party has been fully heard on an issue and the court finds against the party on that issue." Fed. R. Civ. P. 52(c).

The district court invoked that procedure here. The Secretary asseverates that this was not permissible on the facts of this case. We reject this asseveration.

To be frank, we find the Secretary's argument difficult to fathom. The text of the rule is clear. When a party has finished presenting evidence and that evidence is deemed by the trier insufficient to sustain the party's position, the court need not waste time, but, rather, may call a halt to the proceedings and enter judgment accordingly. See Fed. R. Civ. P. 52 advisory committee note ("Subdivision (c) . . . authorizes the court to enter judgment at any time that it can appropriately make a dispositive finding of fact on the evidence."); see also Atl. Track & Turnout Co. v. Perini Corp., 989 F.2d 541 (1st Cir. 1993). The fact that the inmate class had the burden of proof did not place Rule 52(c) off limits. A judgment under Rule 52(c) can be entered for or against either a plaintiff or a defendant, regardless of the allocation of the burden of proof. See Bursztajn v. United States, 367 F.3d 485, 488 (5th Cir. 2004); Fed.

Refin. Co., 352 F.3d at 26; see also 9A Wright & Miller, supra § 2573.1.

Here, the Secretary had advanced his proof and the district court supportably concluded that the Secretary's evidence could not withstand the probative force of the historical record. In other words, even after taking the Secretary's case into account, the court determined that the plaintiffs had sustained their burden of showing pervasive and persistent constitutional violations. Morales IV, 300 F. Supp. 2d at 340-42. The court also supportably determined that the privatization remedy satisfied the narrowness-need-intrusiveness criteria, and that the Secretary's offer of proof did not include any relevant evidence to the contrary. Based on these findings, the district court appropriately entered judgment pursuant to Rule 52(c). That the court made a series of credibility calls in reaching these conclusions in no way detracts from the legitimacy of its approach. See Wright & Miller, supra § 2573.1, at 497-99 (noting that the court's task under Rule 52(c) is to weigh the evidence, without drawing any special inferences in the nonmovant's favor, resolve any conflicts in the evidence, and "decide for itself where the preponderance lies").

IV. CONCLUSION

We are sensitive both to Congress's manifest desire to limit federal judicial oversight of state correctional systems and to the length of time that Puerto Rico's prisons have been under federal hegemony. These concerns impel us to counsel the parties and the district court to move forward as swiftly as possible to cross the threshold of constitutional adequacy so that federal judicial involvement may cease. For now, however, we

accept the well-documented judgment of the district court — a court intimately acquainted with the details of this litigation and the intricacies of the Puerto Rican correctional system — that inmate health care remains constitutionally unacceptable and that the privatization remedy holds promise for bringing inmate health care into compliance with constitutionally mandated standards.[8] Consequently, we reject the Secretary's current effort to vacate or terminate the existing consent decree.

We add a few words of caution. There are now significant financial reserves (in the form of accumulated fines) available for improvements in health care delivery, and the AOC seems willing to work for change. We urge the district court to move toward extricating itself from the toils of this litigation as soon as it can do so without defaulting on its responsibilities under the Constitution.

We need go no further. For the foregoing reasons, we affirm the district court's denial of the Secretary's motion to vacate or terminate the pertinent portions of the existing consent decree. We take no view of the district court's procedural order, see supra Part II, as we lack jurisdiction to review that order on this interlocutory appeal.

Affirmed. Costs shall be taxed in favor of the plaintiffs.

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[8]Should the circumstances change, or a substantial interval pass without significant progress, the Secretary is, of course, free to ask the lower court to reexamine these findings and reconsider the advisability of the ordered relief.

(any footnotes trail end of document)
CIVIL NO. 79-004 (PG)

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF PUERTO RICO

CARLOS MORALES FELICIANO, et al, Plaintiffs,
v.
SILA MARIA CALDERON SERRA, et als, Defendants.

January 26, 2004, Decided
January 26, 2004, Filed

COUNSEL: For CARLOS MORALES-FELICIANO, plaintiff: Carlos V. Garcia-Gutierrez, Jose R. Roque-Velazquez, Civil Action and Education Corporation, Manuel A. Rodriguez-Banchs, San Juan, PR.

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For ALL PLAINTIFFS, plaintiff: Lillian N. Miranda-Rodriguez, Cond. La Arboleda, Guaynabo, PR.

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For JOHNNY RULLAN, defendant: Eileen Landron-Guardiola, Landron & Vega LLP, Eduardo A. Vera-Ramirez, Landron & Vera LLP, Guaynabo, PR.

For MIRLA M. RODRIGUEZ-MARIN, consolidated defendant: Esther Crespin-Credi, Department of Justice, San Juan, PR.

JUDGES: JUAN M. PEREZ-GIMENEZ, U.S. District Judge.

OPINION BY: JUAN M. PEREZ-GIMENEZ

OPINION:

OPINION AND ORDER

On October 1, 2003, Defendant Hon. John Rullan, MD, Secretary of the Department of Health of the Commonwealth of Puerto Rico filed a Motion Under the PLRA to Vacate or Terminate the Court Relief Mandating the Transfer and Privatization of the Correctional Health Program of the Department of Health (Dkt. # 8486) (hereinafter Defendant's Motion). [1] On October 23d the Plaintiff Class opposed and filed a cross motion (Dkt. 8500) to modify the Medical and Mental Health Plans by terminating two sections of those Plans (Dkt. # 1959), and a handful of ancillary orders. A hearing was set for November 4, 2003.

Over the course of several hearings Defendant presented the testimony of Dr. Hector Jose Mena Franco, MD, Executive Director of the Correctional Health Program, Dr. Aida Guzman Font, MD, who headed the Correctional Health Program from April of 1993 through March 2000 and from February 2001 through March 2003 as Chief Health Care Coordinator, Dr. Robert Dennis Jones, MD, who testified as an expert in medical, mental and dental correctional health and administration[2], and the Hon. Miguel Angel Pereira

Castillo, Secretary of the Department of Corrections and Rehabilitation and acting Administrator of the Administration of Corrections. In addition, extensive documentary evidence was admitted into evidence. After the presentation of this evidence Defendant rested on the issues of alleged compliance with the Medical and Mental Health Plans and the supposed lack of current and ongoing constitutional violations.

The order at issue is part of a stipulation or consent decree entered into by the parties in September 1997 as a joint alternative proposal for a remedy to substandard and chaotic conditions or denial of health care throughout the Administration of Corrections, all of which is detailed in the court's Opinion and Order, *Feliciano v. Gonzalez, 13 F. Supp. 2d 151 (D.P.R. 1998).* The court approved and ordered the consent decree executed, without passing on the court's own expert witness' recommendation for a receivership. One important component of the joint proposal was defendants' responsibility to set up a private not-for-profit corporation (the initial organizational communication and operational expenses to be paid for out of fine funds held by the court) which would eventually contract with the Administration of Correction to provide health care to persons in custody of the Administration of Corrections. Extensive testimony and charts were presented during the process in 1997 to be followed until the not-for-profit corporation (eventually registered as the Correctional Health Services Corporation or CHSC) could compete with other providers in Puerto Rico's newly privatized indigents' health care economy in contracting with the AOC.

The Secretary's contention in requesting termination is threefold; that the Correctional Health Services Program is performing efficiently its task of delivering health care to persons in the custody of the AOC, that the CHP is complying with the Medical and Mental Health Plans and, that prisoners' federally protected rights are no longer violated. The Secretary, on his own evidence, is wrong.

FINDINGS OF FACT

The defendant has established that by contracting with private individuals and companies he has greatly enriched the professional staffing his command. He has also established through his own witnesses that fully one fourth of inmates who request sick-call do not get it; only 55% of ambulatory care appointments in fact occur, and only 49% of extra-mural appointments are met (these are specialist consultations for serious conditions, surgery etc.). The quoted percentages are a few points below the 1996-1997 averages, and in the case of outside specialist or hospital appointments the drop is significant, from 61.8% completion in 1996-1997 to 49% at present. All of this is enough to find that there is still a present and ongoing systematic and massive denial of health care to the inmate population in the care of the Correctional Health Program.

In 1998 the court found that "the deficiencies evidenced at the hearing are the result of systematic infirmities in the correctional health scheme, which can be characterized as (a) obstructionist interference from and inefficiency within the Department of Health and other government agencies and (b) the lack of cooperation on the part of the Administration of Correction." *Feliciano, 13 F. Supp. 2d 179-180.* Since

the Secretary has increased expenditures expenditures on professionals and private service companies[3] and inmates still fail to get health care in very substantial numbers (at eroding rates, in fact), the only finding that the court can make is that the Correctional Health Program and the Department of Health continue to fail in the administration of increased resources and continue to violate prisoners federally protected constitutional rights. The court cannot but underline that denial of health services is massive and systematic.

No matter how much the Correctional Health Program blames the Administration of Corrections for the Program's failure, the court cannot accept the present and ongoing mistreatment of plaintiffs because two cabinet secretaries - Health and Corrections - cannot get together to solve custody and transportation issues. Theirs has been and still is a joint responsibility[4] until we all deal with the consequences of Plaintiffs' motion to terminate which we discuss further on. Since 1993 Dr. Aida Guzman, M.D. has been involved with correctional health care. During the present hearings she had this to say about interagency cooperation and the failure to deliver health care:

> Because the problems are the same as in 1997, same problems, problems with access.
>
> It is the same problems, because there has been no actual change in terms of the attitude of the organization of the Administration of Correction in providing access to care; that has not changed.

Tr. at 909:4-13.

The delays in affording inmates with important extra-institutional appointments and medical care paint a grimmer picture than that of 1997. The situation is particularly critical in the Ponce Correctional Complex, Ex. 18, where a significant percentage (just over 20%) of the total inmate population live, including almost 40% of the women under the custody of the AOC. Tr. at 1158:4-7. The Master List of Medical Routes for the Ponce Complex, copy of which was marked as plaintiffs' Exhibit 18, is plagued with instances of patients that missed important medical appointments and procedures due to lack of transportation. For example, between September 23 and September 30, 2003, all of the Ponce inmates that were scheduled for extra-institutional medical appointments -- a total of 72 -- missed them. Ex. 18. Among the appointments missed during that week were 12 mammograms, 6 abdominal/pelvic sonograms, 4 brain CT scans, 2 MRI's, and various orthopedic and oncological evaluations that are described as "important" in the log. Id. On October 15 and 16, 2003, all of the 23 appointments scheduled for those 2 days were also missed. Id. The same was true with the 14 appointments scheduled for October 9, 2003, the 12 for October 7, 2003, and the 18 for October 2, 2003, to name just a few. Id. One of the appointments missed on October 2, 2003 was a surgical intervention that the inmate Luis Martinez Cruz was supposed to have that day. Id. The female Ponce inmates have been left without gynecological medical attention since the end of September 2003, Tr. at 1154:20-1155:2, and are experiencing and have experienced delays of over 6 months to have mammograms performed. Tr. at 524:1-5. Although Exhibit 17 established that such had been the case of inmate Marta Lopez Huertas, hers was not an isolated incident as evinced by Exhibit 18.

As a matter of fact, the last time that a female inmate from Ponce was taken to her scheduled mammogram was on May, 6, 2003. Since then, all of the mammogram appointments have been missed for lack of transportation. Exhibit 18. Inmate Conilia Betancourt Fernandez has been waiting to have a mammogram since April 22, 2003, Ruth Rodriguez Santiago since May 1, 2003, and Maria Cameron Alers since May 15, 2003. From then on, Conilia Betancourt Fernandez has not been taken to 6 mammogram appointments (June 3, June 19, July 15, August 28, September 30, and October 28, 2003), Ruth Rodriguez Santiago, to 4 (June 12, June 19, September 4, and October 2, 2003), and Maria Cameron Alers, to 6 (June 3, June 19, July 15, August 28, September 25, and October 30, 2003). During that same time span, various other female inmates were not transported to their scheduled mammograms on more than one occasion, to wit: Leonilda Santiago Santiago was forced to miss her appointments for August 26, September 25 and October 30, 2003, Norma Rosa Rivera and Betsy Rodriguez Vargas missed their respective appointments for August 28, September 30 and October 28, 2003, Rosa Robles Galarza missed hers for September 18 and October 21, 2003, while Ana Pena Frias had to endure the same outcome on September 23 and October 23, 2003. Ex. 18.

Such extended delays in obtaining medically ordered medical tests is simply unacceptable under any set of standards. Tr. at 1178:25-1179:12. A delay of eleven (11) months for a CT scan is equally untenable. Id. Such was the case of inmate Jose Velazquez Rivera, from Ponce Maximum. Ex. 19. The systemic infirmities

caused by the AOC's lack of cooperation with the CHP persist at present. As Dr. Guzman opined:

> I think that the Administration of Corrections has been consistently and historically unresponsive to the needs of the [correctional health] program and above all to the needs of the patients.

Tr. at 905:18-21.

Despite claims to have done everything possible to ensure inmate's access to appointments, Tr. at 902:17-23, the CHP has exacerbated this problem by inflexibly centralizing its services in a system which has historically suffered from problems with access to medical appointments. Tr. at 902:17-23, 1161:20-24, 1163:4-21. No example of this is more illustrative than the situation which has arisen in Bayamon 501, an institution which houses protective custody inmates, who are at risk of being attacked when placed in the general population. Since that institution's medical area was shut down, injectables can only be given at a neighboring general population institution, Bayamon 1072. Tr. at 583:3-14. This means that insulin dependent patients from Bayamon 501 have to be taken up to twice a day to Bayamon 1072 to receive their shots. Tr. at 578:15-18, 579:5-16. These protective custody inmates sometimes spend the entire day in Bayamon 1072's medical area, which has very poor security, with general population inmates. Tr. at 578:23-25; 579:2-4, 580:7-15, 581:12-25. This same procedure applies to other protective custody inmates from Bayamon 501 who require injections. Tr. at 581:12-25, 583:3-14.

No good reason was given at the hearings by defendant for having to transport these inmates to Bayamon 1072, instead of coordinating a system for providing insulin shots at Bayamon 501. Tr. at 717:6-719:18, 722:10-14, 727:6-14. This problem, seemingly a simply one to solve through mutual cooperation between AOC and CHP, eventually lead to litigation in the Puerto Rico Superior Court which resulted in an injunction being issued against the CHP requiring it to provide insulin shots in the protective custody institution. Tr. at 724; 728:10. Nevertheless, for reasons which are totally incomprehensible, this service is being provided only to the patient who requested the injunction, and the remaining insulin dependent patients are still required to move to another facility on a daily basis to receive their shots. Tr. at 728:3-16. This absurd result is a perfect example of the Department of Health's and Administration of Corrections' senseless inability to work with each other to achieve common goals. This problem is not occurring only because the AOC is not doing its part, but because there is a fundamental failure between both parties to cooperate.

The high level of tension and the utter failure of the AOC and I the CHP to coordinate, communicate, and cooperate is also evident in the fortune of the medical cadre. Developed for the purpose of ensuring security in medical areas and that medical escorts would be available to transport inmates to their medical appointments, Tr. at 770:24-771:2, this remedy has not had the expected results, again, because of the lack of cooperation between AOC and CHP, Tr. at 780:13-781:4, 782:10-16, 902:22-903:9.

Another system-wide problem which persists and downgrades the value or limits the availability of the

health care provided are the inadequate physical facilities. In this regard, Dr. Guzman's testimony was also particularly telling when she characterized the facilities as "shameful for our patients and for our health professionals." Tr. at 904:12-13. Dr. Guzman explained the reasons for the progressive deterioration of the physical plant, when compared to the 1997 conditions, as follows:

> There has been no success in trying to get the collaboration of the Administration of Correction in accessing patients to our services and in the physical facilities. It is the same. In fact they are worse facilities, because around seven years have passed by, in terms of the deterioration of the physical facilities, so they are worse.

Tr. at 909:23-910:4.

There has also been longstanding chronic neglect of the physical facilities for medical area services. Tr. at 761:11-13. The facilities available are small and deteriorated. Tr. at 498:6-7. The lack of appropriate facilities clearly affects the CHP's ability to deliver health services. Tr. at 497:25-498:2.

Infirmary beds are often full and obligate the CHP to keep patients in the emergency room. Tr. at 788:9-13. There is a long waiting list for medical dormitory beds because there are not enough beds to take care of the patients with chronic conditions for whom such housing is necessary. Tr. at 788:16-20. Areas designated for medical dormitories were taken over years ago (in fact, before the Court's 1998 findings) by the AOC for other uses (housing for inmates) and were never returned to

CHP for use as medical dormitories. Tr. at 788:20-789:2. There are no isolation rooms for the management of patients with active tuberculosis. 989:23-990:24.

There are now less Psychiatric Intensive Care Unit (PICU) beds for patients who need acute mental health care services than there were in 1997, twenty, while there has been an increase in the inmate population. Paragraph 8 of the Mental Health Plan requires 2 PICU beds per 1,000 inmates. In 1997, the court found that 25 such beds were required, which left a shortage of 5. At present 30 PICU beds would be required, while there are only 18 PICU beds, Tr. at 811:15-812:4, two of which no longer really function as a PICU. Tr. at 820:18-24. Hence the shortage of PICU beds has now more than doubled when compared to 1997.

The CHP expects to acquire 13 additional beds, but the current waiting list is of 70 patients. Tr. at 598:16-18. Generally throughout the system there are 1,311 inmates, equivalent to 8.7% of the total population, that are being housed in areas that do not provide them with the level of care that their chronic medical or mental conditions require, Tr. at 1260:2-6, all in violation of paragraphs 28 and 29 of the Medical Plan. Ultimately what this means is that persons having medical conditions which require a certain level of constant oversight and attention will simply have to go without.

The CHP again attempts to place the onus of this problem on the AOC. However, although the interagency agreement between AOC and the Department of Health states that the AOC shall provide necessary space for medical services, 708:17-24, the fact is that the Medical Care Plan places responsibility upon the Health Department as well as

the AOC for the provision of adequate medical facilities. Tr. at 735:3-14. In fact, the Department of Health through the CHP has and maintains the correctional psychiatric hospital for the exclusive benefit of the inmates under the custody of the AOC. Even though under the circumstances it may not be reasonable to expect the CHP to build all the facilities it needs, they certainly have not reached out to the Court to request its assistance with this problem, and, from the evidence presented there is no suggestion that they have endeavored to do much more than write a few strongly worded letters and attend a handful of meetings. Tr. at 536: 10-25-537:3-20.

Although, the medical doctors at CHP prescribe medical diets, Tr. at 599: 11-18, medical diets are *still* not being provided to inmates, 1087:1-5, 1088:3-4, 1088:15-17, slowly but surely endangering the health and well being, and in some cases the lives of those patients who require them. *Feliciano v. Gonzalez, 13 F. Supp. 2d 151, 197 (D.P.R. 1998)* Among those who require special diets are insulin dependent diabetics, non-insulin diabetics, patients with renal and hepatic conditions and heart disease. Tr. at 600:1-17. In the April, May and June quarter of 2003, 3,120 diets were prescribed and not provided. Tr. at 609:15-18. Although food service is administered by the Administration of Corrections, there is no evidence that the CHP does anything whatsoever to remedy the longstanding problem of medical diets.

Defendant makes much ado of improvements to the system relating to the CHP's fiscal and administrative autonomy. Tr. at 1305:1-10. In fact, over the past few years since the Court's May 1998 Order, the improvements in the CHP that can be observed are due

entirely to the Court's direct intervention. The fiscal and administrative autonomy as well as the power to contract directly with professionals and service providers were rooted in orders issued by this Court:

> "Q. Doctor, based on your years of experience in the program, what has happened that has assisted the program in achieving, progressing, staffing, supplies, etcetera.
>
> [Dr. Aida Guzman] I think that if you look at this longitudinally, one of the big problems that the program faced in 1997 was the lack of administrative autonomy, everything had to go through a facility, which was the operational branch of the Department of Health. The administrative offices of the program at that time, in 1997 were just offices where documents went by, went through and there was no decision making at the program level. I think that a number of things happened that allowed the program to obtain the administrative autonomy that it needed so that it could recruit, retain, buy, and so forth and so on, all the administrative functions and it started with the Court order in 1997 authorizing the chief health care coordinator to process and sign all contracts and had the responsibility of hiring professional services under contract. That started it. There were a number of administrative orders from the Secretary of Health, I believe there were two of them, that partially, during late 1997 and 1998, partially gave some functions to

> the program in terms of administrative autonomy, but actually they were not really enforced. In 1999 when the AFASS, which again was the operational branch of the Department of Health, closed down, a few months before the closing down of the AFASS agency the program received an administrative order from the Secretary of Health, 141 which really gave autonomy to the program. It gave the authority to appoint temporary positions, it gave autonomy to contract hospital and services in the community, it also gave the authority to prepare and negotiate and present some budgets to the office of management and budget. It allowed the program to establish and develop the auction board which was very important in terms of obtaining equipment, materials, medications, etcetera, because the program up until then depended entirely on a facility, so that it gave the program the autonomy that it really needed to enhance the recruitment of very much needed professional personnel. And I think that that really helped.

Tr. at 887:17-889:10; see also Tr. at 672:1-21, 674:16-19, 676:11-13, 676:17-677:4. In fact, the administrative order Dr. Guzman refers to states that it is issued, in part, under authority of the Orders of the Morales Feliciano case. Dr. Mena, the present Executive Director of the CHP, continues to benefit from those court orders even though he is not, in point of fact, covered by them. Tr. at 678:1-17. In addition, the infectious disease control program began to function properly when the Court

allocated fine monies to the purchase of computer equipment and software necessary for the program's day to day work. Tr. at 848:19-851.

Despite these improvements, the Department of Health has been unable to comply, substantially or otherwise, with constitutional norms and with the Medical and Mental Health Care Plans. The CHP still suffers from a whole string of problems that adversely affect inmates' health care.

Having written manuals and guidelines is necessary in order to maintain accountability in the provision of health services. Tr. at 1187:20-1188:3. Nevertheless, only 1 of 8 treatment protocols for mental conditions has been prepared for a meager 12.5% compliance rate with paragraph 9 of the Medical Plan, which requires "written protocols for the delivery of medical, dental and mental health services." Tr. at 1262:23-1263:13. The suicide protocol (prevention manual) is still wanting while suicides have substantially increased from 1 in 2002 to 7 during the first 9 months of 2003. Tr. at 1075:25-1076:5, 1189:13-21, 1077:20-22.

There are currently 1085 inmates with an HIV diagnosis; yet there are only 340, or 31.3%, undergoing treatment for that condition. Tr. at 1263:24-1264:7. Likewise, there is no protocol currently in place for the management of HIV patients. Tr. at 531:16-8. Hepatitis C Virus ("HCV") has reached epidemic proportions by infecting 4,828 inmates or close to a third of the total population. Tr. at 1165:20-1166:4. Yet, there were only 117 inmates undergoing treatment for that condition during the last quarter of fiscal year 2002-03. Tr. at 659:6-10.

Dr. Mena attempted to explain the abysmal disproportion between those numbers by testifying that 73.4% of the infected inmates did not meet the established treatment criteria. Tr. at 660:1-6. However, Dr. Jones clarified during his cross-examination that that figure did not mean that those inmates would never meet the criteria. Tr. at 1170:4-8.

A pilot study conducted in the West Detention Center during the last quarter of 2001-2002 found that almost a quarter (23%) of all HCV inmates did not meet the treatment criteria although they did have elevated liver enzymes twice in a period less than 6 months. Based on those findings and in light of the disease's progression, Dr. Jones opined that he would expect a high number of those inmates to have elevated liver enzymes when tested after the 6 months threshold period, thus becoming eligible for treatment. Tr. at 1175:14-1176:3. Dr. Jones further opined that those patients would have to be followed-up closely and that, treatment should be initiated immediately after they met the criteria. Tr. at 1176:6-14. Although Dr. Jones testified that he understood that the required, close follow-up was being provided, he could not offer a satisfactory explanation of why the most current data at the CHP concerning the HCV epidemic was more than six-months-old, dating back to April of 2003. Tr. at 1172:7-1174:7. Meanwhile, deaths caused by HCV increased fourfold in 2002, jumping to 12 from the 3 deaths that occurred in both 2000 and 2001. Exhibit 14. The number of deaths caused by HCV as of September 30, 2003 has already doubled each of the totals for 2000 and 2001. Id.

While inmate mortality rates are on the rise, the CHP is not addressing that phenomenon with the sense

of urgency that the situation requires. Inmate deaths up-surged in 2002 to 73 from 50 in 2001 and 47 in 2000. Exhibit 14. That is roughly a 25% increase over the two preceding years. Tr. at 1059:21-1060:8. Inmate deaths as of September 30, 2003 have already surpassed the total deaths that occurred in each of 2000 and 2001.[5]

Under Puerto Rico Law, the Institute of Forensic Medicine is obliged to conduct an autopsy in each of the following set of circumstances:

> (4) When the death occurs while in custody of the Police or officers of law and order; while in prison, or as a result of sickness or injury occurring while in prison, or suspicion thereof.
>
> ...
>
> (6) When it is due to acute intoxication with alcohol, narcotics, or any other type of drug or controlled substances or suspicion of such.
>
> (7) When it is due to suicide or suspicion of such.

34 LPRA § 3011. Even though Puerto Rico law requires autopsies under these circumstances, autopsies are not routinely practiced upon persons who die while incarcerated and it appears that the CHP does nothing to compel the Forensic Science Institute to observe this requirement. Tr. at 1111:10-12, 1071:20-1072:13, 1073:14-20, 1105:14-1106:13. No doubt this hinders the CHP's ability to fully review the medical circumstances surrounding deaths which occur within

the system. Although Dr. Jones generally opined that the CHP was properly monitoring, investigating and addressing the increased inmate mortality rate, he was forced to admit that the Annual Report of the Central Level Quality Assurance Committee for fiscal year 2002-03 did not discuss or mention the topic as it should have had. Tr. at 1129:6-1130:8. He further admitted that he did not verify whether appropriate mortality review documents are compiled by the CHP. Tr. at 1125:6-14, 1127:15-1128:4.

Pursuant to paragraph 70 of the Medical Health Plan, one of the matters that the Quality Assurance Committee must evaluate and monitor is precisely inmate mortalities. ("At a minimum, the Quality Assurance Committee shall review inmate mortalities ...") Although the latter have been increasing since 2002, the Defendant did not present a shred of evidence that would permit the Court to infer that the situation is being adequately addressed. Quite to the contrary, the Quality Assurance Committee, which is supposed to hold quarterly meetings, did not meet during the April, May and June quarter of 2003. Tr. at 516:13-25. In fact, there was a dramatic increase in withdrawal deaths in 2002, jumping from a stable trend of 1 or 2 per year to 9 in 2002 and 6 during the first nine months of 2003. Tr. at 1060:16-22, 1068:19-25, 1069:3-11. Even though Defendant's expert, based on his interviews with clinicians, concluded that the rise in these deaths is due to a new designer drug, Fentanyl, Tr. at 1063:10-17, 1066:9-14, 1068:14-17, from his own testimony it appears that the CHP has taken no precautions to alert medical personnel throughout the system of this increased risk. Tr. at 1187:10-19. And the failure to do death review properly increases the probability of never finding out

whether the hypothetical Fentanyl or other designer or vulgar drugs are causing the deaths.

Wellness clinics, yet another requirement of the Medical Plan, are not performed at satisfactory levels as admitted by Dr. Mena. During fiscal year 2002-03 the overall compliance rate fluctuated from 29% in the first quarter, to 36% in the second quarter, 29% in the third quarter and 14% in the last quarter of the year. Tr. at 644.

The CHP continues to have serious problems with retrieving medical records, especially in cases of readmissions. During fiscal year 2002-03, there were 3,997 inmates re-admitted to the AOC system. CHP retrieved the records for only 1,315 of them. This means that the medical records of 2,682 re-admitted inmates were not found. That is, CHP was able to retrieve the medical records for only 29.2% of the re-admitted inmate population during the fiscal year ended on June 30, 2003. Tr. at 1265:15-1268:10. Once again the Secretary has had recourse to the private sector to alleviate the missing-records problem and hired Iron Mountain, Inc. to organize records.

The CHP is still suffering from a shortage of psychiatrists. Tr. at 836:4-10. This is particularly critical at Guerrero, which is not only an intake center but has a psychosocial unit. Tr. at 121:2-14, 240:13-17, 432:20-25, 613:20-614:5, 705:23-24. Guerrero has been without the services of a psychiatrist for several months. Tr. at 614:1-5. In fact, although staffing is much better than it once was, there continue to be generally some important gaps in terms of required professional medical staff. Tr. at 524:1-5, 525:15-19, 613:17-24, 614:1-5, 836:4-10, 885:21-886:7, 1090:10-16, 1156:19-24.

In 1997, psychiatric and mental health services reached only 25% of the inmates in need of them. In 2003, the situation has improved, since, according to Dr. Guzman's most recent estimates, the CHP is reaching 60% of the inmates in need of psychiatric and mental health care. Tr. at 842:14-18. However, the current level is still far short of the 95% targeted rate. *Feliciano, 13 F. Supp. 2d, at 179.*

The critical nature of the problems still confronted by inmates whose health is seriously jeopardized because of the way medical services are administered by the CHP and the AOC is attested to by the significant number of grievances filed by them pursuant to the administrative remedies procedure of the CHP. Tr. at 1178:7-10, Ex. 19. And the CHP directs complainants to file a grievance with the Administration of Corrections.

THE REMEDY

Under the *Prison Litigation Reform Act* ("PLRA"), "Prospective relief shall not terminate if the court makes written findings based on the record that prospective relief remains necessary to correct a current and ongoing violation of the Federal right, extends no further than necessary to correct the violation of the Federal right, and that the prospective relief is narrowly drawn and the least intrusive means to correct the violation." *18 U.S.C. § 3626(b)(3).*

What must be first considered and borne in mind in dealing with health care in this case is that the Administration of Corrections runs a "mixed" jail/prison incarceration system with prisoners locked up in forty (40) institutions dispersed throughout the length and breadth of Puerto Rico: some are grouped in

"complexes" of five or six institutions near important urban centers (Rio Piedras, Bayamon, Ponce) and some are isolated and near nothing much by way of hospital and specialist availability. There are five admission, intake facilities at Rio Piedras, Bayamon, Vega Alta, Ponce and Guerrero. The second consideration that must be taken into account is the longstanding, documented time and again history of noncompliance with Court orders.[6] Compliance and care are in direct inverse proportion to the seriousness of these constitutionally deep-rooted rights of the plaintiff class. The frequency of transfers added up to those factors make it necessary for the Court to fashion and grant system-wide relief.

The Prison Litigation Reform Act of 1995, dismembered and codified in various titles of the United States Code, sets a Sphinx's question for courts and litigants who must seek and order relief for violations of jail and prison inmates' constitutional rights: *§ 3626 of Title 18*, at various places requires the parties not to request, and orders that the courts of the United States "shall not grant or approve any prospective relief unless the court finds that such relief is [simultaneously] narrowly drawn, extends no further than necessary to correct the violation of the Federal right and is the least intrusive means necessary to correct the violation of the federal right." Additionally, "the court shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the relief." *§ 3626(a) and (b)* passim. This language mimics long standing requirements for injunctive relief under *Rule 65 of the Federal Rules of Civil Procedure.* Referred to in the cases as the "need-narrowness-intrusiveness findings"

this is the old "over broadness" doctrine used to measure garden variety injunctive relief under *Rule 65*.

A decade before the PLRA was enacted, Federal courts had well settled doctrines and standards on the issuance of equitable relief. It is well worth quoting in extenso from *Toussaint v. McCarthy, 801 F2d 1080, 1086-1087 (9th Cir. 1986)* which discusses pre-PLRA standards and doctrines in relation to constitutional violations by state actors in contextualized language:

> We agree with the Fifth Circuit's description of the role of the federal courts. Injunctive relief against a state agency or official must be no broader than necessary to remedy the constitutional violation. *See Milliken v. Bradley, 433 U.S. 267, 280, 53 L. Ed. 2d 745, 97 S. Ct. 2749 (1977)* (remedy must be related to condition alleged to offend the constitution); *Swann v. Charlotte-Mecklenburg Board of Education, 402 U.S. 1, 16, 28 L. Ed. 2d 554, 91 S. Ct. 1267 (1971)* (task is to correct, by a balancing of the interests, the condition that offends the constitution; judicial powers may be exercised only on the basis of a constitutional violation); *Hoptowit v. Spellman, 753 F.2d 779, 785 (9th Cir. 1985)* (judge must order correction of specific violations and may require only that these corrections bring the conditions above constitutional minima); *Newman v. Alabama, 683 F.2d 1312, 1319 (5th Cir. 1982)* (relief must be no broader than necessary to remedy the constitutional violation), cert. denied, *460 U.S. 1083, 76 L.*

Ed. 2d 346, 103 S. Ct. 1773 (1983); *Hoptowit v. Ray, 682 F.2d 1237, 1246 (9th Cir. 1982)* (function of court is limited to determining whether a constitutional violation has occurred and to fashioning a remedy that does no more and no less than correct that particular constitutional violation); *Ruiz v. Estelle, 679 F.2d 1115, 1144-46 (1982)* (court must fashion the least intrusive remedy that will still be effective). "The federal courts do not sit to supervise state prisons, the administration of which is of acute interest to the States." *Meachum v. Fano, 427 U.S. 215, 229, 49 L. Ed. 2d 451, 96 S. Ct. 2532 (1976).*

In fashioning a remedy for constitutional violations, a federal court must order effective relief. *Smith v. Sullivan, 611 F.2d 1039, 1044 (5th Cir. 1980).* Therefore, a federal court may order relief that the Constitution would not of its own force initially require if such relief is necessary to remedy a constitutional violation. *See North Carolina State Board of Education v. Swann, 402 U.S. 43, 46, 28 L. Ed. 2d 586, 91 S. Ct. 1284 (1971)*; *Swann v. Charlotte-Mecklenburg Board of Education, 402 U.S. 1, 15-16, 91 S. Ct. 1267, 28 L. Ed. 2d 554.* A defendant's history of noncompliance with prior court orders is a relevant factor in determining the necessary scope of an effective remedy. *Hutto v. Finney, 437 U.S. 678, 687, 57 L. Ed. 2d 522, 98 S. Ct. 2565 (1978)*; *Hoptowit v. Ray, 682 F.2d at 1247*;

Ruiz v. Estelle, 679 F.2d at 1155-56. [Emphasis added.]

However, our goal is to cure only constitutional violations. *Swann v. Charlotte-Mecklenburg Board of Education, 402 U.S. at 16; Wright v. Rushen, 642 F.2d 1129, 1133-34 (9th Cir. 1981).* The commission of a federal judge is not a "general assignment to go about doing good." *Jett v. Castaneda, 578 F.2d 842, 845 (9th Cir. 1978).* Accordingly, injunctive restraints that exceed constitutional minima must be narrowly tailored to prevent repetition of proved constitutional violations, and must not intrude unnecessarily on state functions. *Ruiz v. Estelle, 679 F.2d at 1156. See* generally *Mishkin,* Federal Courts as State Reformers, *35 Wash. & Lee L. Rev. 949 (1978).*

The Ninth Circuit is blunter:

> Although the PLRA significantly affects the type of prospective injunctive relief that may be awarded, it has not substantially changed the threshold findings and standards required to justify an injunction. To this extent we agree with the Sixth Circuit [sic] that "the (PLRA) merely codifies existing law and does not change the standards for determining whether to grant an injunction." *Smith v. Ark. Dept's of Correction, 103 F3d 637, 647 (8th Cir. 1996).*

Gomez v. Vernon, 255 F3d 1118, 1130 (9th Cir. 2001).

Finding the "need -- narrowness - intrusiveness" equation in a given case seems a gamble in the absence of contextuality and lends itself to gross linguistic, two-level manipulation. The Second Circuit provides an example in *Benjamin v. Fraser, 343 F.3d 35, 53-54 (2d Cir. 2003)*:

> The City also contests as overly broad and burdensome the court's requirement that all windows designed to be opened must be operational. Contending that under the PLRA the district court was obliged to consider the utility of each window individually, the City observes:
>
> The effect of a window defect depends upon the nature and degree of the defect, and the nature of the housing area, as well as the outside temperature. For example, a single window in a dayroom or modular unit that is stuck open a crack in mild weather, or one window that will not open among many windows that are operational in a particular area, will not cause unconstitutional conditions in that area. (Def. Br. at 48).
>
> But it is ironic that the City, which strenuously opposes the OCC's continued participation, invokes the PLRA, which was intended in part to prevent judicial micro-management, in support of the proposition that the district court was required to examine every window. We agree with the district court that a comprehensive repair

program would be more effective and less intrusive than an individual review of each window at the various facilities.

Although the PLRA's requirement that relief be "narrowly drawn" and "necessary" to correct the violation might at first glance seem to equate permissible remedies with constitutional minimums, a remedy may require more than the bare minimum the Constitution would permit and yet still be necessary and narrowly drawn to correct the violation. Given the impracticability of the court examining each window, ordering comprehensive repairs was a necessary and narrowly drawn means of effectuating relief-even though the Constitution would certainly permit a broken window or two.

See also *Jones El v. Berger, 164 F. Supp. 2d 1096, 1116 (W.D. Wis. 2001)*, citing *Smith v. Arkansas Dep't of Correction, 103 F.3d 637, 647 (8th Cir. 1996)* (preliminary injunction standard not changed.)

In this case three quite different remedies to the long-standing, current and ongoing violations of plaintiffs' health care constitutional rights have been presented. The defendants propose themselves, in the face of historical, systematic failure and current and ongoing massive violations: hope that peripheral improvements continue and maybe, sometime in the future, plaintiffs will actually receive health care. The defendants' own evidence established that as of today a quarter of those who request sick calls do not get them, and half of those who must travel to extrainstitutional appointments, which are ordered in serious cases of

medical need, do not make it to the appointment. Half of prisoners who must be moved intrainstitutionally do not make their appointments and the CHP does not reach 40% of prisoners in need of mental health care. In spite of higher levels of budgeting and staffing the defendants still cannot provide care to their charges. The most daunting of the reasons, the principal reason offered by the defendants' evidence is the utter inability of the Correctional Health Program, which depends on the Department of Health, to coordinate with the Administration of Corrections for custody and transportation. This particular institutional failure exists ever since the Department of Health took over by court order and interagency agreement the responsibility for the delivery of health care to persons under the custody of the Administration of Corrections. Under Commonwealth law the Administration of Corrections is charged with the responsibility for prisoners' health care. *4 LPRA § 1112(f).*[7]

In 1997 the Court commissioned an expert witness, Vincent M. Nathan, Esq. to prepare reports on compliance with the then extant remedial orders and to submit the health care report first of all. The expert witness complied and proposed that correctional health care be placed in a receivership because the Correctional Health Program could not deliver. The plaintiffs opposed the creation of a receivership and proposed the creation of a private not-for-profit corporation as an alternative remedy. The defendants opposed both the receivership and the not-for-profit corporation in their historical denial of reality. After two weeks of hearings an agreement between the parties was reached and a joint request was presented to the Court to allow the development and to fund the

organization of a nonprofit corporation. *Feliciano v. Gonzalez, 13 F. Supp. 2d 151 (D.P.R. 1998).*

The Court granted in 1998 a necessary remedy and among the three alternatives chose the creation of a nonprofit corporation proposed jointly by the parties as the least intrusive and most narrowly drawn. The very fact that the defendants chose to join the plaintiffs in selecting this remedy would seem to mean - and must be taken to mean -- that they understood it to be precisely tailored to the needs of the occasion, that it is narrowly drawn and least intrusive - in fact not intrusive at all.[8]

It is not happenstance that so many of the violations shown by the defendants' proof at the present hearings have to do with delays in transportation to outside appointments. The CHP is over-dependent on the use of the Puerto Rico Medical Center for hospital and specialist services. This was to be expected. The CHP depended in 1997, as it depends now, on outside hospital facilities and specialist services: for decades indigents and then prisoners had depended on the services rendered by the Department of Health through AFASS (Administration for Health Facilities and Services). In 1993 the structures and economy of hospital and health services began to change, and dramatically so.

With the approval of the Puerto Rico Health Insurance Act in September 1993, *24 LPRA 7001 et seq.* the dependence on the Department of Health for uninsured indigents began to crumble away and as the Health Reform progressed throughout the decade it became obvious that it was best to place prison inmates in the hands of the Administration of Corrections and a not-for-profit corporation than to leave them stranded

as the sole charges of a Department of Health denuded of health care capabilities: this became critical when AFASS was dissolved and public, especially regional, hospitals were sold.

The Legislative Intent of the Puerto Rico Health Insurance Act, *24 LPRA § 7001* of 1993 has an eerie resemblance to the reform history of this case, in part it reads:

> From the beginning of this century, Puerto Rico's public policy has revolved around the attitude that the Government has the responsibility of offering direct health services.
>
> Pursuant to such policy, two health systems have evolved which are notably unequal. In general terms, we can state that the quality of health care in Puerto Rico has come to depend predominantly on the financial capability of the person to cover the cost thereof with his/her own resources.
>
> Within this scheme, the Department of Health has assumed the care of the medically indigent sector of our population. The well-intended efforts of its officials have not been sufficient to counter the adverse effects which factors such as the following have had on the quality of the Department's services: budget insufficiency; increasing costs of technology and medical supplies; bureaucracy and government centralization; and political partisan interference with its efforts. [Emphasis added.]

> Since 1967, there have been several attempts in Puerto Rico to reform medical-hospital services offered by the Department. However, it has not been possible to narrow the ever growing gap between the quality of public and private services.

This history of failing reform is what this case's long history of health care violations parallels.

The remedies fashioned by the court to correct the constitutional violations pertaining to Plaintiffs rights in the area of medical and mental health care have run the gamut from general injunctions, to more specific injunctions, to detailed and itemized plans, to pertinent modifications fine tuning particular portions of those plans, to complementary orders addressed to particular obstacles to the delivery of adequate care to inmates, to, finally, the 1998 Opinion and Order which attempts to alter the way mental and medical health services to inmates are delivered, in order to make this delivery more efficient and competitive. All of this in an effort to correct what continues to be the unconstitutional manner in which inmates' health care is provided or not provided at all in the AOC. The record of this case demonstrates that pre-1997 efforts to correct current and ongoing constitutional violations in the medical area, have failed. It is, therefore, indisputable that in order to be effective, it is necessary that the relief ordered by this court reach out for new solutions. Instead of the relief proposed by the court's expert in 1997, receivership, this court approved the less intrusive remedy proposed in the joint proposal of 1997 to create the Correctional Health Services Corporation. This was and continues to extend no further than

necessary to correct the violation of the Federal right, and is narrowly drawn and constitutes the least intrusive means to correct the violation. See *18 U.S.C. § 3626(b)(3)*.

The best remedy was and remains a nonprofit corporation which when finally operational can work in the new private medical and health services economy. The defendants' evidence shows beyond speculation that right now the CHP depends at a disadvantage on the private sector on everything from lab testing and record storage and retrieval to medical and nursing personnel. Tr. at 552:2-5, 554:8-9, 601:1-24, 680:23-681:22. This is done in an *ad hoc*, helter-skelter way, as the need arises and failure is specifically disastrous - a psychiatrist is missing at the Guerrero facility which is supposed to operate two programs for mental health patients and addicts (La Posada - a psychosocial unit -- and intake) and a pharmacist at Zarzal. Tr. at 121:2-14, 240:13-17, 432:20-25, 613:20-614:5, 705:23-24. The Corporation can contract with the Administration of Corrections to provide services and plan: at present the Corporation, for example, has developed a telemedicine program to provide psychiatric services at Guerrero to correct for the impoverished availability of mental health personnel in the Western half of Puerto Rico. Tr. at 503:9-12. Thus, the creation of the not-for-profit corporation will lead to the restoration of the AOC's authority under Commonwealth law as the provider of health care to inmates, eliminate the present and intolerable duality in authority, and discharge the Secretary of Health from his court-imposed responsibilities.

The Court has financed through the use of fine funds the development of a modern health care services

infrastructure: computerized health records to solve the age old danger of the untransported or lost charts and the treatment disasters that tens of thousands of expedientillos or temporary records produced; the system is scheduled to begin in April 2004. Tr. at 670:18-671:1. The Corporation is now at an acute point in the training of personnel to use that system and to abort that development would cause imminent and grievous harm to the plaintiffs by perpetuating a patently unconstitutional denial of their health care.

The only intrusion the Corporation represents is the need to access information and the attendance of personnel at training sessions. The need to remedy constitutional violations which are current and ongoing in undisputable and legally mandated. *Estelle v. Gamble, 429 U.S. 97, 50 L. Ed. 2d 251, 97 S. Ct. 285 (1976)*; *North Carolina State Board of Education v. Swann, 402 U.S. 43, 28 L. Ed. 2d 586, 91 S. Ct. 1284 (1971)*; *Swann v. Charlotte-Mecklenburg Board of Education, 402 U.S. 1, 28 L. Ed. 2d 554, 91 S. Ct. 1267 (1971)*. If Federal courts are to exercise the judicial power of the United States, then they must provide a remedy to a plaintiff who complains about and proves violations of his constitutional rights when a case and controversy is properly presented within the court's jurisdiction. The court cannot understand how the work performed by the Corporation is either overintrussive or overbroad: access to records has worked out so well that there is now a computerized systemwide network due to begin operations as soon as personnel are trained. And the few hours needed to train personnel is an intrusion de minimis compared to the health care benefits that will accrue to the plaintiff class. The government has not done it, the Corporation has.

The Corporation is not meant to have an exclusive, perennial right to deliver health care to prisoners. Once organized and structured it will compete in a free market with others. One or two years of Court overseen contracting will prepare the Administration of Corrections - under Commonwealth law the government agency responsible for prison health care - for the task of negotiating with the private sector and making whatever choice is legally available.

The parties were instructed at the beginning of the hearing on these matters that they should limit their evidence to the existence or not of constitutional violations to the members of Plaintiff Class. Tr. at 172:2-9. Defendant wishes, further, to present evidence on the necessary-narrow-least intrusive inquiry. Tr. at 171:10-21. Given the severe time constraints imposed by the PLRA, and the potentially unnecessary delay in the implementation of much needed improvements generated by the CHSC, and the halting of functions already provided by the CHSC, the Court requested that Defendant Rullan make a proffer as to the evidence he wishes to present in this regard. Tr. at 1321:2-13. Based on the proffer made by Defendant Rullan in open Court, the evidence he wishes to present in this regard will add nothing to the inquiry this Court must make in order to resolve defendant Rullan's PLRA motion, it is simply irrelevant.

When first asked to make a proffer, Defendant responded through counsel with a generalized allegation that, "the Corporation is not the least intrusive remedy because they, as of this date have not provided the type of medical services that are being provided by the Correctional Health program" Tr. at 1321:21-24. When doing nothing is "intrusive" was not

explained and the assertion was made in bad faith. The Corporation's development is behind schedule but it has already provided computer equipment and established an interinstitutional communication network at the central level, and contributes with the administrative part in purchases, personnel and in accounting and finance and in addition, to medical billing, according to Dr. Mena's testimony. Tr. 502-503. When the court insisted upon the specifics, Defendant stated that he wished to take discovery on the matter. Tr. at 1322:7-15. Why Defendant could not have prepared himself by taking discovery prior to filing the PLRA motion rather than burdening this court's already constrained time to issue a decision on his PLRA motion was not explained.[9] Regardless of whatever need may exist to obtain particularized facts in order to more efficiently present their evidence, the matters Defendant Rullan proposes to conduct discovery on have no bearing on the issues to be decided by this court. Rather, it appears that Defendant Rullan wishes to conduct a smear campaign in an effort to show that the persons operating the CHSC are corrupt or somehow morally reprehensible and/or incompetent and that the CHSC is not ready at present to provide the necessary health care - a point which is not disputed by any one since the CHSC has not completed its organization.

The presentation of such evidence is unnecessary to the court because it in no way addresses the question of whether the challenged relief is "narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right." Rather, the evidence Defendant Rullan wishes to present is directed to whether the CHSC is

operating as it should in light of state law requirements and the orders of this Court.[10] None of the factual matter specified by Defendant Rullan in his proffer suggest any need for alarm; but if Defendant Rullan has concerns about how the CHSC is being operated, etc., he should feel free to bring those to the Court's attention in order to request that the Court take steps to address those concerns. These facts do not, however, render the relief entered by the Court in 1998 more intrusive, less narrow or less necessary; nor do they implicate any serious need to modify that relief.

On January 14, 2004 a unanimous Supreme Court decided *Frew v. Hawkins, 540 U.S. , 157 L. Ed. 2d 855, 124 S. Ct. 899 (2004).*[11] The Court stated the controversy involved thus: "Judicial enforcement of [a] 1996 consent decree is the subject of the present dispute. The decree is a detailed document about 80 pages long that orders a comprehensive plan for implementing the federal statute. In contrast with the brief and general mandate in the statute itself, the consent decree requires the state officials to implement many specific procedures". *Frew, 157 L. Ed. 2d 855, 124 S. Ct. 447.* The Court further explained: "To ensure the enforcement of federal law, however, the *Eleventh Amendment* permits suits for prospective injunctive relief against state officials acting in violation of federal law. *Ex Parte Young, 209 U.S. 123, 52 L. Ed. 714, 28 S. Ct. 441 (1908).* This standard allows courts to order prospective relief see *Edelman v. Jordan, 415 U.S. 651, 39 L. Ed. 2d 662, 94 S. Ct. 1347 (1974); Milliken v. Bradley, 433 U.S. 267, 53 L. Ed. 2d 745, 97 S. Ct. 2749 (1977),* as well as measures ancillary to appropriate prospective relief, *Green v. Mansour, 474 U.S. 64, 71-73, 88 L. Ed. 2d 371, 106 S. Ct. 423 (1986)* [...]"

The Court then goes on to describe the nature of a consent decree in terms that fit nicely the issues before the court:

> Consent decrees have elements of both contracts and judicial decrees. *Firefighters v. Cleveland, 478 U.S. 501, 519, 92 L. Ed. 2d 405, 106 S. Ct. 3063(1986).* A consent decree "embodies an agreement of the parties" and is also "an agreement that the parties desire and expect will be reflected in, and be enforceable as, a judicial decree that is subject to the rules generally applicable to other judgments and decrees." *Rufo v. Inmates of Suffolk County Jail, 502 U.S. 367, 378, 116 L. Ed. 2d 867, 112 S. Ct. 748 (1992).* Consent decrees entered in federal court must be directed to protecting federal interests. In *Firefighters*, we observed that a federal consent decree must spring from, and serve to resolve, a dispute within the court's subject-matter jurisdiction; must come within the general scope of the case made by the pleadings; and must further the objectives of the law upon which the complaint was based. *478 U.S., at 525.*

Frew, 157 L. Ed. 2d 855, 124 S. Ct. 899 . This is especially pertinent to the court's decision because the joint proposal, the court's approval in May 1998 and subsequent orders brings this matter within the Firefighters doctrine. In Frew the Court went on to restate the obvious: "Federal courts are not reduced to approving consent decrees and hoping for compliance.

Once entered, a consent decree may be enforced." Slip Opinion at 9.

Finally the Court teaches

> When a federal court has entered a consent decree under *Ex parte Young*, the law's primary response to these concerns has its source not in the *Eleventh Amendment* but in the court's equitable powers and the direction given by the Federal Rules of Civil Procedure. In particular, *Rule 60(b)(5)* allows a party to move for relief if "it is no longer equitable that the judgment should have prospective application." The Rule encompasses the traditional power of a court of equity to modify its decree in light of changed circumstances. In *Rufo v. Inmates of Suffolk County Jail, 502 U.S. 367, 116 L. Ed. 2d 867, 112 S. Ct. 748 (1992)*, the Court explored the application of the Rule to consent decrees involving institutional reform. The Court noted that district courts should apply a "flexible standard" to the modification of consent decrees when a significant change in facts or law warrants their amendment. *Id., at 393.* See also *Philadelphia Welfare Rights Org. v. Shapp, 602 F.2d 1114 (CA3 1979)* (modifying consent decree implementing Pennsylvania's EPSDT program in light of changed circumstances).
>
> *Rufo* rejected the idea that the institutional concerns of government

officials were "only marginally relevant" when officials moved to amend a consent decree, and noted that "principles of federalism and simple common sense require the [district] court to give significant weight" to the views of government officials. *502 U.S., at 392, n. 14.* When a suit under *Ex parte Young* requires a detailed order to ensure compliance with a decree for prospective relief, and the decree in effect mandates the State, through its named officials, to administer a significant federal program, principles of federalism require that state officials with front-line responsibility for administering the program be given latitude and substantial discretion.

The federal court must exercise its equitable powers to ensure that when the objects of the decree have been attained, responsibility for discharging the State's obligations is returned promptly to the State and its officials. As public servants, the officials of the State must be presumed to have a high degree of competence in deciding how best to discharge their governmental responsibilities. A State, in the ordinary course, depends upon successor officials, both appointed and elected, to bring new insights and solutions to problems of allocating revenues and resources. The basic obligations of federal law may remain the same, but the precise manner of their discharge may not. If the

> State establishes reason to modify the decree, the court should make the necessary changes; where it has not done so, however, the decree should be enforced according to its terms.

Frew, 157 L. Ed. 2d 855, 124 S. Ct. 899 The Secretary, however, has not moved for modification but for termination.

The court has no doubt that the moving defendant's own evidence establishes that the Correctional Health Program is still malfunctioning, that the medical and mental health Plans are not nearly being complied with and that egregious and systematic violations of plaintiffs federal, constitutional rights to health care are being violated. The CHCC is still necessary: the Correctional Health Program of the Department of Health is simply not doing the job. The Administration of Corrections is blamed and the AOC by itself is not prepared to take over the task. The Corporation has been developing systems and can continue to help along the agency charged by Commonwealth law to do the job.

Far from proving Defendant Rullan's case, the evidence presented shows that there currently continue to be ongoing constitutional violations of the rights of Plaintiff Class in the areas of medical and mental health care and that Defendant is not in compliance with the Medical and Mental Health Care Plan. Plaintiffs request that, based on the evidence presented by Defendant, judgment be entered denying Defendant's PLRA Motion under *Fed. R. Civ. P. 52(c)*.

APPLICABLE LAW

The duty of prison authorities to incarcerated inmates is well settled law. The *Eighth Amendment* prohibits punishments which are incompatible with "the evolving standards of decency that mark the progress of a maturing society," *Trop v. Dulles, 356 U.S. 86, 100-101, 2 L. Ed. 2d 630, 78 S. Ct. 590 (1958)*; *Weems v. United States, 217 U.S. 349, 378, 54 L. Ed. 793, 30 S. Ct. 544 (1910)*, or which "involve the unnecessary and wanton infliction of pain," *Gregg v. Georgia, 428 U.S. 153, 173, 49 L. Ed. 2d 859, 96 S. Ct. 2909 (1976)*. Government officials are therefore required by the Constitution to provide medical care to those who are incarcerated:

> An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical "torture or a lingering death," the evils of most immediate concern to the drafters of the Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose. The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency as manifested in modern legislation codifying the commonlaw view that "it is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself."
>
> We therefore conclude that deliberate indifference to serious medical needs of

> prisoners constitutes the "unnecessary and wanton infliction of pain," proscribed by the *Eighth Amendment.* This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed. Regardless of how evidenced, deliberate indifference to a prisoner's serious illness or injury states a cause of action under *§ 1983.*

Estelle v. Gamble, 429 U.S. 97, 103-106, 50 L. Ed. 2d 251, 97 S. Ct. 285 (1976) (citations and footnotes omitted). Thus, it is required that mental, see *Torraco v. Maloney, 923 F 2d 231, 234 (1st Cir. 1991)* (citations omitted) (there is "no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart.'") and medical health services be provided at a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards. *U.S. v. DeCologero 821 F.2d 39, 43 (1st Cir. 1987).* A lack of funds will not excuse the failure of correctional systems to maintain a certain minimum level of medical service necessary to avoid the imposition of cruel and unusual punishment. *Harris v. Thigpen, 941 F.2d 1495 (11th Cir. 1991).*

A constitutional violation is therefore established when government officials show deliberate indifference to those medical needs which have been diagnosed as mandating treatment, conditions which obviously require medical attention, conditions which

significantly affect an individual's daily life activities, or conditions which cause pain, discomfort or a threat to good health. *Brock v. Wright, 315 F.3d 158, 162 (2nd Cir. 2003)*; see also *McNally v. Prison Health Servs., 28 F. Supp. 2d 671, 673-4 (D. Maine 1998)* (treatment for HIV). Accordingly, the following have been held to implicate *Eighth Amendment* rights in the area of mental and medical health care:

> a. Neglecting to fully screen incoming inmates or to detect mental health problems. *DeGidio v. Pung, 920 F.2d 525, 529-33. (8th Cir. 1990)*; *LaReau v. Manson, 651 F.2d 96, 109 (2nd Cir. 1981)*; *Inmates of Occoquan v. Barry, 717 F. Supp. 854 (D.D.C. 1989)*.
>
> b. Failing to provide a sick call system that ensures access to care and that is capable of effectively handling emergencies. *Bass v. Wallenstein, 769 F.2d 1173 (7th Cir. 1985)*.
>
> c. Failure to take steps to minimize the risk of inmate suicide, see generally, *Partridge v. Two Unknown Police Officers, 791 F.2d 1182 (5th Cir. 1986)*, and appropriate treatment for suicidal patients, *Comstock v. McCrary, 273 F.3d 693 (6th Cir. 2001)*.
>
> d. "Interfering with the treatment once prescribed." *Estelle, 429 U.S. at 105.* Examples of this form of deliberate indifference are

i. the failure to appropriately administer necessary medication, *Montgomery v. Pinchak, 294 F.3d 492 (3rd Cir. 2002)* (HIV); *Wynn v. Southward, 251 F.3d 588 (7th Cir. 2001)* (heart medication); *Roberson v. Bradshaw, 198 F.3d 645 (8th Cir. 1999)* (diabetes);

ii. the failure to provide transportation to scheduled specialty appointments and other therapy, *Kaminsky v. Rosenblum, 929 F.2d 922 (2nd Cir. 1991)*; *Waldrop v. Evans, 871 F.2d 1030 (11th Cir. 1989)*; and

iii. The failure to provide prescribed medical diets. *Roberson v. Bradshaw, 198 F.3d 645 (8th Cir. 1999)*; *Kyle v. Allen, 732 F. Supp. 1157 (S.D. Fla. 1990)*.

e. Delays in diagnosing and administering appropriate treatment. *Clement v. Gomez, 298 F.3d 898 (9th Cir. 2002)*; *H.C. v. Jarrard, 786 F.2d 1080 (11th Cir. 1986)*

f. The failure to provide appropriate post surgical care. *Boretti v. Wiscomb, 930 F.2d 1150 (6th Cir. 1991)*; *Wood v. Sunn, 865 F.2d 982 (9th Cir. 1988)*.

g. Cohabitation of severely mentally ill patients with the general population without being tendered any type of mental health treatment, *Cortes-Quinones v. Jimenez Nettleship, 842 F.2d 556, 560-61 (1st Cir. 1998).*

h. Failure to provide a sick call system that ensures the needed care. *Bass by Lewis v. Wallenstein, 769 F.2d 1173 (7th Cir. 1985).*

i. Failure to provide adequate facilities and equipment. *Langley v. Coughlin, 888 F.2d 252 (2nd Cir. 1989), Inmates of Allegheny County Jail v. Wecht, 874 F.2d. 147 (3rd Cir. 1989).*

j. Inadequate record keeping and records management which are critically important to the continuity of medical care, otherwise, the possibility for disaster is created. *Montgomery v. Pinchak, 294 F.3d 492 (3rd Cir. 2002); Miranda v. Munoz, 770 F.2d 255 (1st Cir 1985).*

These and other wrongs of constitutional import have been found by this Court to exist and to constitute violations of the rights of the Plaintiff Class as set out in this Court's Opinion and Order of 18 May 1998. *Morales Feliciano v. Rossello Gonzalez, 13 F. Supp. 2d 151, 179 (D.P.R. 1998).* The historical systemic indifference to inmates' medical and mental health needs and the institutional failures which up to this day continue to threaten the health and the medical safety and well-being of the Plaintiff Class require the

continued operation of relief granted in favor of the Class as well as the continued supervision of this Court. See generally, *LaMarca v. Turner, 995 F.2d 1526 (11th Cir. 1993).*

Based on the evidence presented by Defendants there can be no doubt that all of the above conditions continue to prevail at AOC. These demonstrate that relief remains necessary to address current and ongoing constitutional violations in the areas of medical and mental health care.

The Medical and Mental Health Plans unequivocally impose a joint responsibility upon both the AOC and the Department of Health for the delivery of health care to the inmates. See P1 of the Medical Plan. The Plans further require interdepartmental cooperation between both agencies to achieve its goals. See P4 of the Medical Plan. By doing so, the Medical and Mental Health Plans adopted the principles of cooperation, trust and teamwork between the medical and correctional components of a prison system that are required under every set of standards, be it the Constitution, ACA or NCCHC, to be able to provide timely and adequate medical services to the inmates. Tr. at 1096-97.

When this restructuring of responsibilities, agreed to and voluntarily undertaken by all parties involved, was initiated, it involved executive and administrative orders issued by state officials under state law to transfer primary healthcare responsibilities to the Secretary of Health. See e.g. Ex. D. These orders were issued pursuant to and under the authority of a consent decree. Simply put, under the Constitution and Medical and Mental Health Plans the AOC and the DOH are

partners or co-venturers in the delivery of the medical and mental health services to the Plaintiff Class. *Wilson v. Town of Mendon, 294 F.3d 1, 14-15 (1st Cir. 2002)* (Joint venture theory succeeds where a defendant "'associated himself with the venture, participated in it as something he wished to bring about, and sought by his actions to make it succeed.'"); see also cases relating t joint liability under § *1983 Northington v. Marin, 102 F.3d 1564 (10th Cir. 1996); Weeks v. Chaboudy, 984 F.2d 185 (6th Cir. 1993); Finch v. City of Vernon, 877 F.2d 1497 (11th Cir. 1989).*

Hence, Defendant Rullan's pretension of putting the blame for the serious and pervasive access problems, the sheer inadequacy of the physical facilities and the failure to provide medical diets exclusively on the shoulders of the AOC, fails as a matter of law.

As discussed above, based on the record of this case and on the evidence brought before the Court the relief relating to the CHSC was and continues to extend no further than necessary to correct the violation of the federal right, and is narrowly drawn and constitutes the least intrusive means to correct the violation. *18 USC § 3626(b)(3).*

PLAINTIFFS' CROSS MOTION

In their opposition to Defendant's Motion the plaintiff class cross-moved to terminate two sections of the Medical Plan assigning the primary responsibility of inmates health care to the Department of Health so that responsibility would return to the Administration of Correction, which is the agency designated by Commonwealth law to provide medical, dental and mental health services to the inmate population, *4 LPRA § 1112(f).* By returning to the Administration of

Corrections the plaintiffs seek to unify responsibility and accountability. At present the Secretary of Health blames the Administrator of Corrections for his flagrant failures and nothing, it seems, can be done to make both agencies work together. The Defendant joins the plaintiffs. Typically the defendants join because, in any case, they will continue the same disastrous present arrangements by interagency agreement as a matter of "public policy". n12 They will of course do so at their peril. The defendants and their counsel have not brought forth any basis for this unknown public policy.

The plaintiffs' request is framed thus:

> The scheme set up to place control and responsibility in the DOH has not worked because of conflicting patterns of authority and command lines. For years on end the conflict has survived even when the defendants have called on the Court's authority to help out. The plaintiffs continue to suffer, as shown above, by such inter-departmental conflicts. The plaintiffs must request that the Court terminate Part I (A) (1) and (2) of the Medical Plan. The plaintiffs also move that all orders relating to the Medical Cadre be terminated: these are Order to Implement Medical Cadre Plan, Dkt. # 6977; Order To Assign Correctional Officers to the Medical Cadre (several docket numbers are: 7345; 7417; 7453, and 7574). Other Orders referring to budget and transitory matters touching the Medical Cadre are docket numbers 7106; 7418; 7611.

There are a number of orders requested by the parties to dispose of all kinds of problems with administration and execution of the Medical and Mental Health Plans, all of them, usually requested by defendants and plaintiffs, attend transient matters, are now useless and sometimes confusing. They are: Order that the Chief Correctional Health Care Coordinator Take All Necessary Contractual Steps to Maintain Continuity of Services to Inmates in the Custody of the Administration of Corrections, (Dkt. # 6558); Order Regarding Compensation Scale for Correctional Health Employees and Contractors (Dkt. # 6830); Order Regarding Purchase of Vehicles for Correctional Health Program (Dkt. # 6855); Order stating that Dr. Ernesto Torres Arroyo, MD as Executive Director of the Correctional Health Program shall take all necessary steps to enforce his line of authority, etc. (Dkt. # 7573); Endorsed Order of 6/30/97 regarding Joint Motion Stating the Fiscal Arrangements Which Shall Be Made to Pay for the Professional Services Contracted for by the Chief Health Care Coordinator Pursuant to the Court's order of 16 May 1997 (Dkt. # 6567).

THE MOTION TO INTERVENE

The Union General de Trabajadores, affiliated to the SEIU, Local 1199 on November 7, 2003 filed a motion to intervene under *Rule 24 (b) of the Federal Rules of Civil Procedure* to join the Secretary's motion, to argue that the privatization of services will put at risk health

services and to announce the pendency of two resolutions in the Commonwealth Legislative Assembly and suggesting that it would be prudent to wait until the Senate and House investigations are over before holding hearings (Dkt. # 8523). The court took the motion under advisement and invited counsel to remain; counsel left. The Motion for intervention certainly is not timely, the Union has not specified the commonality of fact or law required by the Rule and has left in the hands of management's lawyers the unions representation. The Union's participation in this case would add nothing but complexity and confusion. The bizarre arrangement whereby the Union's interest are represented by counsel for management is unintelligible.

RULE 52 (c)

Under *Rule 52(c)*, district courts are authorized to enter judgments based on partial findings once a party has presented its evidence with respect to a particular issue:

> Judgment on Partial Findings. If during a trial without a jury a party has been fully heard on an issue and the court finds against the party on that issue, the court may enter judgment as a matter of law against that party with respect to a claim or defense that cannot under the controlling law be maintained or defeated without a favorable finding on that issue, or the court may decline to render any judgment until the close of all the evidence. Such a judgment shall be supported by findings of fact and

> conclusions of law as required by subdivision (a) of this rule.

Fed. R. Civ. P. 52 (c). According to Moore's, "A judgment of partial findings may be invoked when: (1) The party pursuing the claim has not demonstrated the elements of the claim either in fact or in law; or (2) the evidence of the party pursuing the claim has established one of the opposing party's defenses as a matter of fact or law." James Wm. Moore et al., Moore's Federal Practice, P52.50[2] (3d ed 2003). In this case the Rule is properly invoked on both counts: the defendant Secretary has failed to prove his allegations and has established to the satisfaction of even the PLRA, that massive numbers of plaintiffs fail to access and receive health care services for very serious conditions because the systems in place do not work.

Upon the findings and conclusions set out above IT IS SO ORDERED AND ADJUDGED that:

> (1) Defendant's Motion Under the PLRA to Vacate or Terminate the Court Relief Mandating the Transfer and Privatization of the Correctional Health Program of the Department of Health is denied.
>
> (2) Plaintiffs' Cross Motion is granted. Therefor Part I(A)(I) and (2) of the Medical Plan is terminated, as well as Order to Implement Medical Cadre Plan, (Dkt. # 6977) and the various orders to assign officers to the Medical Cadre (Dkt. # 7345); (Dkt. 7417); (Dkt. 7453); (Dkt. 7574); (Dkt. 7106); (Dkt. # 7418), and (Dkt. 7611). Other

orders terminated are: Order that the Chief Correctional Health Care Coordinator Take All Necessary Contractual Steps to Maintain Continuity of Services to Inmates in the Custody of the Administration of Corrections, (Dkt. # 6558); Order Regarding Compensation Scale for Correctional Health Employees and Contractors (Dkt. # 6830); Order Regarding Purchase of Vehicles for Correctional Health Program (Dkt. # 6855); Order stating that Dr. Ernesto Torres Arroyo, MD as Executive Director of the Correctional Health Program shall take all necessary steps to enforce his line of authority, etc. (Dkt. # 7573); Endorsed Order of 6/30/97 regarding Joint Motion Stating the Fiscal Arrangements Which Shall Be Made to Pay for the Professional Services Contracted for by the Chief Health Care Coordinator Pursuant to the Court's order of 16 May 1997 (Dkt. # 6567).

(3) The Union de Trabajadores Motion To Intervene is denied.

IT IS FURTHER ORDERED that the Secretary of Corrections and the plaintiff class shall meet and file with the Court within forty-five (45) days of the entry of this order a plan on how the Administrator of Corrections will assume his legal responsibility to provide health care to inmates.

At San Juan, Puerto Rico, this 26 day of January 2004.

JUAN M. PEREZ-GIMENEZ

U.S. District Judge

Footnotes

[1] Although the unsigned certificate of service indicated that a copy of the PLRA Motion was served on Plaintiffs' counsel on that same date, it was not delivered to Plaintiffs until October 8, 2003, after a telephone request by Plaintiffs' counsel. The allegedly mailed copy was never received.

[2] After his cross-examination plaintiffs moved to strike Dr. Jones' opinion testimony. The court declines to do so. Dr. Jones formally meets the criteria for delivering expert testimony. After his cross-examination, however, the court gives very little credence to those opinions.

[3] Some of these contracts do not provide full services: the CHP has a long standing contract with Clendo Laboratories to perform laboratory services: pick-up and delivery happen once a day. ("Panic" results are transmitted to the CHP by fax when the tests show results which need immediate attention.) The CHP, however, has no capacity at all to do STAT testing. Tr. At 554:18-20. STAT test results are necessary when a patient is in critical conditions that require an immediate response. Tr. At 1160:23-1161:5.

[4] Moreover, under Puerto Rico law physicians are required to make certain that their medical orders are carried out. Tr. At 900:24-901:8, 902:7-9.

[5] The accuracy of the 2003 death statistics came into question during the cross-examinations of doctors Mena and Jones. While the Mortality

Report, a copy of which was admitted into evidence as plaintiffs' Exhibit 14, recorded 51 deaths until September 30, 2003, plaintiffs presented 62 death summaries for that same period, which were marked as Exhibit 16. While Dr. Mena was not able to explain the discrepancy in the numbers, Dr. Jones ventured to say that the Mortality Report only recorded deaths with a known cause. Tr. at 1122:20-1123:2, 1126:6-19; 1127:6-8.

[6] The Court has set out this history in detail, *Feliciano v. Gonzalez, 13 F. Supp. 2d 151, 156-159 (D.P.R. 1998).*

[7] The only competence, in correctional health under the laws of the Commonwealth assigned to the Secretary of Health is stated at *4 LPRA § 1112(l)* which refers to procedures under the Security Measures of Puerto Rico's Penal Code, arts. 66 et seq. *33 LPRA § § 3351 et seq.* which are not in use. The only explanation for the Secretary of Health to be involved in this matter at all is that the parties agreed to bring the Secretary of Health and the Secretary of Anti-Addiction Services together with the Administrator of Corrections in one section of the Correctional Health Plan (Amended Sixty-Second Report of the Court Monitor) (Docket # 1959) and order adopting the stipulated plan (Docket # 2465). The plaintiff class has moved to terminate that section of the medical plan and the defendants have joined them.

[8] There must be no doubt that this court's order of May 15, 1998 approved the joint proposal

for the creation of a not-for-profit corporation as part of the remedy to the violations of plaintiffs' constitutional rights to health care. The order ended by requiring counsel for the parties to report on progress, *Feliciano, 13 F. Supp. 2d at 214*, which led to any number of meetings and to substantial financial support for the development of the corporation, all of which is spread on the record.

[9] The defendant also issued and served trial subpoenas requiring the production, from the Corporation and its board members, a broad spectrum of documents for five or six years.

[10] Any violation of commonwealth law however unspecific would be a matter for Commonwealth courts and other agencies, not for this Court. And the utter absence of specificity in Defendant's proffer denudes the proffer of any credibility.

[11] Frew arises under a Medicaid program, Early and Periodic Screening, Diagnosis and Treatment. (ESPDT), Title *42 USC § § 1396a(a)(43), 1396d(r)*).

[12] The Supreme Court of Puerto Rico has unequivocally stated that the Commonwealth's public policy is established by the Constitution of Puerto Rico, the statutes enacted thereunder and their judicial interpretation. *Hernandez Torres v. Hernandez Colon, 129 P.R. Dec. 824, 878, 1992 Juris P.R. 16 (1992)*, citing *Ocasio Carrasquillo v. Rosa Berrios, 21 P.R. Offic. Trans. 29, 121 P.R. Dec. 37, 1988 Juris P.R. No. 42 (1988)*; *Ortiz Andujar v. ELA; 122 P.R. Dec. 817, 22 P.R. Offic. Trans. 774, 1988 Juris P.R. 147 (1988)*; *Hurd v.*

Hodge, 334 U.S. 24, 92 L. Ed. 1187, 68 S. Ct. 847 (1948). The last volume of the Supreme Court's decisions to be published in English is volume 100.

CIVIL NO. 79-4 (PG)

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF PUERTO RICO

CARLOS MORALES FELICIANO, et al.,
Plaintiffs,

v.

PEDRO ROSSELLO GONZALEZ, et al.,
Defendants.

May 15, 1998, Decided
May 18, 1998, Filed

COUNSEL: For CARLOS MORALES-FELICIANO, plaintiff: Rafael Perez-Bachs, McConnell Valdes, Jeffrey M. Williams-English, Indiano, Williams & Weinstein-Bacal, Jose E. Fernandez-Sein, Carlos Garcia-Gutierrez, Harry Anduze-Montano, San Juan, PR.

For CARLOS MORALES-FELICIANO, plaintiff: Carlos E. Ramos-Gonzalez, Old San Juan, PR.

For CARLOS MORALES-FELICIANO, plaintiff: Nora L. Rodriguez-Matias, Guillermo J. Ramos-Luina, Hato Rey, PR.

For CARLOS MORALES-FELICIANO, plaintiff: Steven Martin, Austin, TX.

For KSP SURETY & BONDING CORPORATION, Civ. 93-1985, consolidated plaintiff: Rafael F. Castro-Lang, San Juan, PR.

RAYMOND RIVERA-RIOS, CV 93-2387(PG), consolidated plaintiff, Pro se, Mayaguez, PR.

EFRAIN ORTIZ-VEGA, consolidated plaintiff, Pro se, Bayamon, PR.

EDWIN MARCUCCI-CARABALLO, consolidated plaintiff, Pro se, Rio Piedras, PR.

JOSEPH MAYA-GAMBINO, consolidated plaintiff, Pro se, Ponce, PR.

JOSE G. PENA-SANCHEZ, consolidated plaintiff, Pro se, Bayamon, PR.

For RAFAEL HERNANDEZ-COLON, LORENZO VILLALBA, JOSE E. DR. JOSE E. SOLER ZAPATA, JOSE A. NUNEZ-LOPEZ, Dr., ISABEL SULIVERES, VICTOR A. VAZQUEZ-GONZALEZ, JUANITA GOMEZ, HERIBERTO ACEVEDO, JULIO ACEVEDO-ASENCIO, JULIO GARCIA-GARCIA, JULIAN O. MCCONNIE, JOSE L. CRUZ-RAMOS, CARLOS ROMERO-BARCELO, IRBA CRUZ DE BATISTA, JUAN DEL-VALLE-LOPEZ, FELIX RODRIGUEZ-PINERO, ZULMA MARTINEZ-DE-CONE, MERCEDES OTERO-DE-RAMOS, defendants: Marcos A. Ramirez-Lavandero, San Juan, PR.

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For PEDRO ROSSELLO-GONZALEZ, ENRIQUE VAZQUEZ-QUINTANA, Dr., JOHNNY COLON, defendants: Marshal D. Morgan, Hato Rey, PR.

For PEDRO ROSSELLO-GONZALEZ, defendant: Daliah Lugo-Auffant, P.R. Department of Justice, Civil Rights Legal Task Force, San Juan, PR.

For PEDRO ROSSELLO-GONZALEZ, defendant: Rick Nemcik-Cruz, Rio Grande, PR.

For OTTO RIEFKOHL, consolidated defendant: Charles S. Fax, Shapiro & Olander, P.A., Baltimore, MD.

For OTTO RIEFKOHL, consolidated defendant: Luis Guinot, Jr., Washington, DC.

JUDGES: JUAN M. PEREZ-GIMENEZ, U. S. District Judge.

OPINIONBY: JUAN M. PEREZ-GIMENEZ

OPINION:

OPINION AND ORDER

1. On March 10, 1997, the court entered an order appointing Vincent M. Nathan, Esq., the former Court Monitor, as an expert witness pursuant to *Rule 706, Fed. R. Ev.*, to prepare a report that would update the record in this case and document the state of compliance with the court's orders. The court directed Mr. Nathan to submit a report on medical and mental health care. Mr. Nathan's report concluded that "there is virtually no likelihood that the defendants, left to their own devices, will ever achieve compliance with the court's orders in the areas of medical and mental health care or will ever provide services in these areas that comport with even the most basic constitutional requirements." Report on Medical and Mental Health Care at 39 (filed April 14, 1997, admitted in evidence over objection as CT Exhibit 13). Accordingly, Mr. Nathan recommended that the court appoint "a receiver with ample authority to manage the Correctional Health Program free of all constraints of Commonwealth law." Id. at 40. That report and recommendation set the stage for the instant proceedings.

2. The Court received motions from both the plaintiffs and the defendants opposing the court's expert witness's recommendation of a receiver. Motion to Submit Plaintiffs' Specific Alternative to the Court's Expert Witness' Recommendation that a Receiver Be Appointed to Resolve the Correctional Health Program Crisis (Dkt. 6559, May 19, 1997); Supplemental Motion on Plaintiffs' Proposed Alternative to a Receivership for the Correctional Health Program (Dkt. 6590, June

26, 1997); Final Supplement to Plaintiffs' Specific Alternative to the Court's Expert Witness' Recommendation that a Receiver Be Appointed to solve the Correctional Health Program Crisis (Plaintiffs' Alternative) (Dkt. 6615, August 8, 1997); Defendants' Motion Requesting Additional Time to Address Plaintiffs' Alternative Recommendation to the Expert Witness' Report on the Correctional Health Program (Dkt. 6565, May 30, 1997); Defendants' Supplement to Their Correctional Health Program Crisis Proposal (Dkt. 6627, August 18, 1997). The Court scheduled a hearing to commence August 18, 1997, to address the recommendation and the current state of medical and mental health care in the prison system.[1] The Correctional Health Program is referred to as the Program or the CHP. After the hearing was concluded, the parties submitted a Plaintiff Class' and Defendants' Joint Proposal Concerning Correctional Health Program (September 26, 1997).

3. At the hearing, 13 witnesses testified. In general, the witnesses were distinguished professionals knowledgeable about the Puerto Rico prison system, and highly credible, with such exceptions as set out below.[2] In addition to the testimony, close to seven hundred documentary exhibits were submitted by plaintiffs and stipulated by defendants including considerable statistical data concerning the operation of the Correctional Health Program. Additional documentary evidence was submitted on behalf of the Court's Expert Witness, without objection by the parties. Some documents were admitted over objection.

I. FINDINGS OF FACT

4. The defendants in this litigation have been subject to court orders to improve the delivery of health care services to inmates dating back to the court's preliminary injunction of 1980. *Feliciano v. Barcelo, 497 F. Supp. 14 (D.P.R. 1981).* The parties eventually stipulated to the Medical Care and Mental Health plans (together referred to below as the "Plans"). In 1990, the court approved the court monitor's Amended 62nd Report, the Report Recommending Adoption of Revised Medical and Mental Health Plans, which included the Plans. The court's order of approval also ordered defendants to implement the Plans to remedy almost a decade of non-compliance with the court's orders to provide constitutionally required health care. As a result, the Administrator of Correction and the Secretary of Health agreed to transfer the responsibility for correctional health services to the Department of Health. In 1986, after further hearings, the court found inter alia that the preliminary injunction had not been complied with. The court appointed Vincent M..Nathan, Esquire, as the Court Monitor, to monitor compliance with its orders, including those addressing medical and mental health care. *Morales Feliciano v. Romero Barcelo, 672 F. Supp. 591 (D.P.R. 1986).*

5. In 1980, health care services within Puerto Rico's prisons were virtually nonexistent. There was one psychiatrist for the entire system, which had custody at that time of approximately 3,000 inmates. Mentally ill patients at Bayamon 308 were housed in what was known as the "maxima de locos" (maximum for crazies), where they received virtually no attention and the distribution of medication was carried out by other inmates. There were three, perhaps four physicians to

provide medical services to the entire AOC inmate population. There were no licensed pharmacists in the system.

6. In 1988, the Administration of Correction entered into an agreement with the Department of Health by which correctional health services were to be rendered by Department of Health personnel. By 1993, the program under which such services were provided was just beginning to develop an identity of its own and was designated the Correctional Health Program. At the same time, the services at the institutional level were severely disorganized and understaffed and still relied upon unlicensed personnel. The services were not integrated and each "track" of services--e.g., nursing, mental health, etc.--responded to its own directors at the central office level. There was only one licensed pharmacist for all of the island's penal institutions. Medical records were disorganized and there was not even a rudimentary infectious disease control program. Quality improvement was very fragmented. Health education was done by a psychologist at the central level and was not being extended to the institutions. The administrative aspects of the program were being performed by a single secretary.

7. A 1990 report by the Court Monitor concluded, based on the assessments of two distinguished expert consultants, that "[a] number of conditions found and prohibited by the Court in 1980 persist throughout the correctional system, and the current medical and mental health delivery systems throughout the AOC endanger the lives and health of inmates and staff alike." 100th Report of the Court Monitor--Report on Delivery of Medical and Mental Health Care (Dkt. 2050, at 3, filed February 2, 1990), confirmed by order of June

14, 1990, Dkt. 2268). This conclusion, and the experts' findings, were not contested by the defendants and, indeed, came as no surprise. When the Court Monitor first introduced the consultants to the then Administrator of Corrections, Dra. Mercedes Otero de Ramos, she

> made clear her preference that the consultants not tell her what she already knew at the time-that systems for delivery of medical and mental health care to prisoners throughout Puerto Rico were in near total disarray. Rather, she requested that the consultants provide her with a plan containing proposed solutions to the problems that had been brought to her attention through prior evaluations and her own observations of the correctional system.

Amended 62nd Report of the Court Monitor--Report Recommending Adoption of the Revised Medical Plan and Mental Health Plan at 3 (filed December 13, 1989).

8. Both of the Court Monitor's consultants conferred extensively with representatives of the Administration of Correction and the Department of Health in the course of their work and submitted initial proposed plans for providing adequate medical and mental health care. These became the subject of extensive and cooperative discussion and revision among the parties and the Court Monitor that led to the Medical Care Plan and the Mental Health Plan ("the Plans") that were recommended to the court in the Amended 62nd Report. Neither party objected to any part of the Plans. On January 2, 1990, the court tentatively approved the

Plans and directed the defendants to commence implementing them. Final approval was given by order dated October 23, 1990 (Dkt. 2465), after the court completed the notice and review procedure required by *Rule 23(e), Fed. R. Civ. P.*, which the court followed out of an abundance of caution.

9. Since their entry as orders, these Plans have been supplemented and modified by several further orders addressing certain medical and mental health care issues. See Order Approving Lambert King's Recommendations, December 18, 1992 (Dkt. 4156); Order Confirming 213th Report of the Court Monitor--Report Conveying Medical Consultant's Findings of Site Visits Conducted April 25-28, 1992 and Appendix B of the Report, December 29, 1992 (Dkt. 4166); Order amending § 58 of the Medical Care Plan, July 9, 1993 (Dkt. 4537). At the hearing, the Correctional Health Care Coordinator praised the plans, and she was not alone in doing so.

Goals of the Plans

10. The principal goals of the Correctional Health Program, are fourfold: (1) integration of health services throughout the large and complex institutional system under the jurisdiction of the Administration of Correction; (2) to provide services commensurate with contemporary standards of professional practice of medicine, with emphasis on preventive services to the entire inmate population; (3) to guarantee accessibility for all inmates to the full range of health services available, including hospitalization, emergency services, and subspecialty facilities and clinics; and (4) to provide health education to the inmate population and correctional staff to improve the level of understanding

of sound health and prevention of disease. The services addressed by the Plans include, in addition to direct medical services, all the supporting services necessary to operate an integrated health care system, including, among others, health education, quality improvement, diets, medical records, and administrative support. These goals and services reflect contemporary standards for the provision of adequate health services generally, whether within the free community or within a correctional setting. The general community standards of providing integrated health care services are embodied as well in the standards promulgated by the Joint Commission on Accreditation of Health Care Organizations (the "Joint Commission"). The Health Care Executive Committee had thus proposed the adoption of the standards of the Joint Commission as the benchmark by which to evaluate correctional health services in Puerto Rico.

11. The court specifically finds that the four goals set out in the Plans are essential to any remedy for the elimination of the long-standing and present violation of plaintiffs' federal constitutional rights. Of special importance is the integration of health care services throughout all of the institutions operated, directly or under contract, by the Administration of Correction. While the parties, or the Chief Health Care Coordinator, may from time to time request modifications of the Plans to keep abreast of health care developments or to enhance administrative and fiscal efficiency, any changes must be shown to further these goals.

Historic Noncompliance with the Plans

12. Past and present defendants have not complied with the Plans, as documented in a series of motions and reports by the Court Monitor, as a result of which the court took a series of actions intended to facilitate compliance.

13. In the 202nd Report of the Court Monitor--HIV/AIDS Focused Study (filed July 28, 1992), confirmed August 18, 1992; Dkt. 3839), the monitor found extensive noncompliance with the Medical Plan's requirements with respect to HIV care and concluded that defendants' failure "places HIV-positive prisoner's lives in peril." Id. at 27, Finding 31. The court directed the defendants to implement the report's recommendations.

14. In the 213th Report of the Court Monitor--Report Conveying Medical Consultant's Findings of Site Visits Conducted April 18-25, 1992 (filed September 21, 1992; Appendix B filed October 27, 1992; confirmed December 28, 1992; Dkt. 3966), the monitor's consultants documented noncompliance with the Plans' requirements concerning intake screening, inadequately equipped medical facilities, inadequate staffing of facilities housing chronically ill patients, failure to provide medical diets, unavailability of correctional staff to escort inmates to medical appointments inside and outside the prison, etc.

15. A memorandum of August 12, 1993, addressed to the Department of Health officials reporting the most recent findings of the audits performed at seven prisons by the monitor's medical consultants, the report was very critical of the very little progress achieved toward compliance with the Medical Plan. Office of the Court

Monitor, Summary of the Morales Feliciano Litigation, January 11, 1995 (Dkt. 5532), at 193-94. [3]

16. A June 8, 1993 Stipulation on the Rio Piedras Complex and Other Matters at 12 (Dkt. 4477) described health care at the State Penitentiary as "fragmented, disjointed, thus lacking continuity of care."

17. A similar pattern of noncompliance with the Mental Health Plan was documented in a series of reports including, the Report of the Court Monitor--Report Pursuant to the Court's Order of January 4, 1990 (filed March 16, 1990; confirmed June 13, 1990; Dkt. 2123) (finding acute mental health care at Annex 504 and Vega Alta grossly deficient); 151st Report of the Court Monitor--Report on Delivery of Mental Health Services at Vega Alta at 2 and § II (filed April 25, 1991; confirmed May 21, 1991; Dkt. 2822) (documenting dangerous conditions under which psychotic female inmates had been held, and defendants' failure to remedy the problem); 134th Report of the Court Monitor-- Report on the Delivery of Health Care Services at Guerrero (filed December 7, 1990; confirmed February 4, 1991; Dkt. 2545)(documenting failure to operate special treatment unit in compliance with Mental Health Plan and inadequate, sometimes inappropriate and dangerous, treatment); 168th Report of the Court Monitor--Report on Observations of Mentally Ill Inmates Housed in the Intensive Treatment Unit of the State Penitentiary (filed August 23, 1991; confirmed October 30, 1991; Dkt. 3139) (finding failure to screen inmates in Intensive Treatment Unit consistently with mental health plan and noting breakdowns of communication between AOC and the Department of Health ("DOH") that adversely affected provision of care); 215th Report of

the Court Monitor--Report on Defendants' Progress Toward Compliance with Their Mental Health Plan (filed September 23, 1992; confirmed October 19, 1992; Dkt. 3969) (reporting comprehensive audit finding little progress toward compliance with Mental Health Plan).

II. NEEDS OF THE INMATE POPULATION: HEALTH CONDITIONS

18. The inmate population in Puerto Rico has a disproportionate need for health services, which translates to a similar need for resources-including time, money, equipment, and facilities-to address those health needs. Particularly there is an urgent need for careful planning based on rational budgeting, streamlined procedures, job security and reasonable compensation, adequate staffing (both health care and security personnel), transportation, quick and responsible contracting and acquisitions, and everything else that is needed to set up an organized health care system that provides services to human beings, albeit not the most fortunate human beings. The Commonwealth's Secretary of the Treasury, who testified on behalf of the equitable defendants, and particularly on behalf of the Governor, repeatedly stated "That is unacceptable" when confronted with the obstacles placed in the way of the Correctional Health Program. No explanation was offered for the consistent policies and decisions by highly placed officials which have brought about the present debacle.

19. In general terms, a high percentage of the AOC inmate population has suffered from childhood neglect or abandonment, abuse, or drug abuse, and/or have previously been in juvenile institutions. Even though the average age of population is in the mid-thirties,

there are a disproportionate number of chronic conditions.

20. The prison population in Puerto Rico suffers from a higher overall prevalence of chronic diseases than the general population. The prevalence in the prison population is 20.7 per 100 persons, while the rate in the general population is 12.75 per 100 males. The rate of mental health disorders in the prison population is approximately 30 percent, which is higher than the rate in the general population. The target population in terms of oral health in the prisons is 100 percent. The inmate population is at higher risk for infectious diseases than the general population, and a higher concentration of high-risk illnesses than the free community. The control of infectious diseases is more difficult in the inmate population, first, because inmates tend to be a higher risk population, and second, because of the close confinement of the population. Outbreaks of contagious diseases can more easily become uncontrollable. Based on an outreach performed by mental health staff in 1997, there are an estimated 674 inmates in the Puerto Rico prison system who require mental health care services but who are not receiving such services; of these, approximately 121 should be in an intermediate psychiatric care facility, 464 in ambulatory services, and 89 in the hospital. Approximately 70 percent of the total inmate population in Puerto Rico has a history of drug abuse. This population is a target for mental health services.

21. Approximately 1.4 percent of the total inmate population in Puerto Rico requires acute mental health care. "Acute" mental health care is that care provided to patients who are psychologically decompensated and can involve acute psychosis, severe depression with

suicidal ideations, or drug or alcohol withdrawal. (Acute mental health care is provided in a hospital setting or infirmary for those with drug withdrawal symptoms.)

22. Approximately 1.9 percent of the total inmate population in Puerto Rico requires intermediate mental health care. "Intermediate" mental health care is care provided within a psycho-social residential facility. It is care provided to patients with chronic mental health problems who may need constant care at different levels. Within intermediate mental health units, patients are taught daily living skills, use of medication, and how to detect the onset of acute symptoms. Patients in intermediate facilities also are provided occupational and group therapy.

23. Approximately 27.2 percent of the total inmate population in Puerto Rico requires ambulatory mental health care. Ambulatory mental health services are outpatient services provided in the same setting and integrated with regular out-patient services.

24. Currently in the AOC system, the CHP has identified 131 patients with hepatitis A, 356 patients with HIV, 279 PPD+ patients, 147 patients with AIDS, 198 patients with diabetes, 6 patients with active tuberculosis, 311 patients with high blood pressure, 106 patients with epilepsy, 4 with lupus, 46 with peptic ulcer disease, 4 with leukemia, 4 with chronic obstructive pulmonary disease, and 1 cancer patient. There also are 922 patients with chronic conditions in the privatized institutions.

25. One of the objectives of the Plans is the creation of an integrated health care system. An integrated system for the delivery of health care is necessary because it has a multiplying effect on the delivery of

services. In an integrated system, services are delivered through interdisciplinary teams. An integrated system of health care delivery represents the standard of care in the community and comports with professional standards of care. An integrated system maximizes the benefits that patients receive from the services rendered by the CHP. It is more cost effective, allows patients to receive different levels of care, and is sounder from an administrative perspective. In an integrated system, all prisoners have available to them the same medical services. The CHP cannot achieve acceptable professional standards of care if any one component of an integrated health care systems is not present. As part of an integrated system of medical care, all of the different specialties--medical, mental, and dental care--must work together. If an integrated system of health services is available when an inmate enters the prison system, all health needs that the inmate may have can be identified, and all such needs can be addressed.

26. An integrated health system includes a system for health education. Health education is necessary to the prevention and promotion of health. Inmates with specific medical conditions require education concerning medication, attending appointments, how to determine when medical attention is required, etc. Health education also is important to enable people within the correctional setting to lower their risk of exposure to disease within the institutions.

27. In certain cases, it is necessary to provide unitary dosages of medication to inmates. Unitary dosage of medication is the individual presentation of each dose of medication to a patient, to ensure that the patient is taking the medication properly. Several types

of medications call for unitary doses. For example, the medications used for HIV+ and AIDS patients, for patients with a positive tuberculin test, or active tuberculosis, for patients with mental conditions who must receive psychopharmacological medication, patients who exhibit some kind of physical condition requiring controlled medication, and for epileptic patients. Unitary doses are served by nurses at various times during the day and are taken by the patient in front of the nurse and the custodial officer that accompanies the nurse.

28. Current standards call for placing inmates going through withdrawal symptoms under medical supervision for at least seven days. Failure to provide the necessary treatment can result in dehydration. In addition, withdrawal patients suffer from restlessness and changes in personality. They can be vulnerable and subject to mistreatment or sexual abuse by the general population. Withdrawal from alcoholic intoxication can be a life threatening process.

29. To conduct an effective infection control program, the CHP requires protective isolation and respiratory isolation facilities to control outbreaks of diseases such as tuberculosis. These facilities are also required by OSHA regulations. Isolation rooms should be checked at least every month, and air changes in the rooms should be monitored. Failure of the isolation rooms to work correctly increases the probability of an outbreak of disease among inmates and staff. Infection control nurses should inspect the isolation rooms at least monthly.

30. An integrated health care system requires the maintenance of medical records, which should

accompany inmates who are transferred from one institution to another. Current professional standards also require the maintenance of valid statistics concerning the incidence and prevalence of infectious diseases. [4]

III. POLICY AS AN INSTRUMENT OF CONSTITUTIONAL VIOLATIONS

Budgeting Insufficiencies and Instability

31. Since 1993 the Correctional Health Program has never has been provided with a budget sufficient to provide adequate health care services to inmates. In addition, money has been promised to the Program by the Office of Management and Budget, but never delivered, and the Program has not been able at times, to use even available funds. The Health Services and Facilities Administration (AFASS, the Spanish acronym) has on occasions arbitrarily deducted money from the appropriation assigned for the Program, which cannot submit a budget request directly to the Puerto Rico legislature nor to the Office of Management and Budget. The CHP must, instead, submit a proposed budget request to AFASS. From there on, the Program has no control over what happens to its budget request. Nevertheless, by the time the request reaches the legislature, it has been dramatically slashed. Correctional Health Program personnel are not allowed to be involved in developing the CHP's portion of the Executive Branch's budget, beyond submitting the initial proposal to AFASS.

32. A stable budget is critical for the Program because the administration and management of resources cannot be planned unless the program administrators know how much their budget will be.

The budgeting process under which the CHP operates does not provide any certainty to the program's administrators. Even after funds have been appropriated to the program, the staff is never really sure how much money will be available for the program's operations. Resolving these issues throughout the year diverts attention and efforts from the primary responsibilities of the program.[5] In spite of increasing expenses over the last four fiscal years, and increasing budget petitions, the funds appropriated for the CHP for the 94-95, 95-96, and 96-97 fiscal years did not change significantly.

33. The Puerto Rico Correctional system is not capable of achieving compliance with the medical and mental health care plans under the present administrative arrangements. The inadequate resources allocated to the CHP result in staffing and supply problems. The present financial arrangements for the Program are not sufficient to achieve compliance with the medical care plan. At present, the process for obtaining professional staff to work in the program is insufficient to comply with the medical and mental health care plans. The physical facilities in many of the institutions are inadequate to achieve compliance with both plans.

34. In preparing a budget request for the CHP, institutional staff present their needs to the program's central office and based on these and the central office's own needs, a budget petition for the program is prepared by the central office staff. The program sends the budget petition to the executive director of AFASS, and has no further participation in the budget process. The process of preparing the CHP budget petition begins in September of the prior year, and the

Governor's budget petition is presented to the legislature in February or March. The appropriations are made by June 30th and arrive at the program during the first or second week of July of the new fiscal year.

35. The Chief Health Care Coordinator was not involved in preparing the budget for the 1992-1993 or the 1993-1994 fiscal years, because those budgets already had been prepared by the time of her appointment. The budget appropriation for the CHP, including the Correctional Psychiatric Hospital, during the 1993-1994 fiscal year was approximately $ 18.4 million. Late in 1993, however, the program was notified that $ 1 million would be subtracted from the appropriation, and later was notified that an additional $ 1 million would be subtracted from the appropriation. No explanation was forthcoming for either subtraction. Exhibit 613. See also Exhibits 331-334. After the CHCC sought assistance from the Secretary of State, then the Governor's Personal Representative anent this litigation, the $ 2 million was restored to the program, along with an additional $ 686,505.00. In spite of the additional $ 686,505.00 provided the CHP in the 1993-1994 fiscal year, the program had a budget shortfall of nearly $ 2 million for that year.

36. For the 1994-1995 fiscal year, the CHP submitted a budget petition of approximately $ 27.5 million, but was appropriated only $ 22.6 million for operational expenses. The program also had requested approximately $ 9.5 million for the Correctional Psychiatric Hospital, but was appropriated only $ 8.4 million. The total amount appropriated to the CHP, therefore, was $ 31 million. During the 1994-1995 fiscal year, the government withheld 4 percent of the total

funding for government agencies to pay incentive bonuses to government employees. In addition, 2 percent of funds appropriated for government agencies was withheld as a contingency fund. This policy affected the CHP as well as all government agencies, but no amounts were withheld from the appropriation for the Correctional Psychiatric Hospital. As a result of the 4 percent incentive pay withholding and the 2 percent withholding for contingencies, the resulting amount available for planning to the CHP, including the Correctional Psychiatric Hospital, during the 1994-1995 fiscal year was $ 29.785 million.

37. After the Chief Health Care Coordinator requested assistance from the Secretary of State in late 1994, $ 2.2 million of the amount appropriated for the Correctional Psychiatric Hospital was transferred to the CHP for its operations. The Secretary of Health promised to cover any further deficiencies that might occur in the program's budget for that fiscal year. In addition to the $ 2.2 million transfer from the Correctional Psychiatric Hospital, the CHP was restored the 6 percent withheld for merit bonuses and contingencies, although the restoration of these funds did not occur until three weeks before the end of the fiscal year in which they were appropriated. The total funding available for the program in the 1994-1995 fiscal year, therefore, was $ 24,826,064. The Chief Health Care Coordinator managed to obtain the transfer of funds from the Correctional Psychiatric Hospital and the restoration of funds from the contingency and merit bonus funds after plaintiffs filed a motion for a preliminary injunction to compel defendants to adequately fund the CHP.[6]

38. Expenditures by the CHP in fiscal year 1994-1995, however, were approximately $ 31 million, leaving the program with a deficit of approximately $ 6.3 million. It cannot be determined how the $ 6.3 million deficit was covered, because the responsibility for covering costs and expenditures of the program falls upon AFASS.

39. For the 1995-1996 fiscal year, the CHP submitted a budget request for approximately $ 64.6 million. This amount includes $ 15.2 million for the Correctional Psychiatric Hospital, $ 38.4 million for the CHP's operations, and $ 11 million for the medical surgical unit. The medical surgical unit was to be a secure unit for tertiary care for inmates, to minimize reliance on outside facilities: this component of the health care system also has not been developed. The amount appropriated for the CHP for the 1995-1996 fiscal year was approximately $ 34.2 million, which is just under 50 percent of what was requested. The $ 34.2 million included $ 2 million appropriated for the Correctional Psychiatric Hospital, and $ 32.2 million for CHP operations. Although the Correctional Psychiatric Hospital could not be opened during the 1995-1996 fiscal year, the CHP already had hired staff for the hospital based on the promises made to her that the Hospital was nearing completion.

40. At a meeting in June 1995, the Secretary of Health agreed to make available $ 48.3 million to the CHP. These funds would consist of the full $ 38 million requested for CHP operations and approximately $ 10 million for the Correctional Psychiatric Hospital. In spite of the Secretary of Health's promises at the June 1995 meeting, only $ 40 million was assigned to the CHP consisting of the original $ 32 million

appropriated, plus an additional $ 8.4 million. The additional $ 8.4 million assigned to the CHP disappeared from AFASS' information system in June 1996 because the Office of Management and Budget had decided not to make the monies available through AFASS' accounting system. Instead, the program would be allowed to spend up to $ 5 million and any excess would be covered by AFASS from its own budget. The CHP spent $ 40 million in fiscal year 1995-1996, leaving a deficit of $ 7.8 million. This is typical of the unstable budgeting practices which make rational, efficient and cost effective management impossible as a direct result of the defendants' policy acts and omissions.

41. For fiscal year 1996-1997, the CHP requested a budget of $ 75.5 million, including $ 50.8 million for the program's operations, $ 12.8 million for the Correctional Psychiatric Hospital, and $ 11.8 million for the Medical Surgical Unit. The total amount appropriated to the CHP for fiscal year 1996-1997 was $ 31 million for the program's operations. This amount also was supposed to include the Correctional Psychiatric Hospital. In addition to the $ 31 million appropriated to the CHP's operational budget, two special assignments totaling $ 900,000 were made to the Program. Although no funds had been specifically appropriated to the CHP for the Correctional Psychiatric Hospital for fiscal year 1996-1997, in May 1996 the Governor signed an executive order awarding $ 2 million for opening the Correctional Psychiatric Hospital, which was accomplished in August 1996.

42. Given the anticipated shortfall in funding for the CHP in fiscal year 1996-1997, in July 1996 the Director of the Office of Management and Budget agreed to

award an additional $ 20 million to the program. In spite of the promise by the OMB Director, the $ 20 million never was made available to AFASS for CHP's budget.[7] In May 1997 the Governor signed an executive order transferring $ 20 million from the Budgetary Fund for use by the CHP. These funds were placed within the Department of the Treasury. The Governor's executive order of May 1997 did not actually provide the CHP with an additional $ 20 million, but merely reinstated the $ 20 million that the Director of the OMB had promised the program the previous year.

43. At the time of the hearing it was still not known how much the CHP spent in fiscal year 1996-1997 (which had ended on June 30) because AFASS ceased making payments to contractors and suppliers and the program's expenses are currently are being paid for from the $ 20 million in the control of the Department of the Treasury. The process of determining how much money is owed by the program still hasn't been completed. Of the $ 20 million placed in the control of the Treasury Department, approximately $ 8 million were used to pay debts of the CHP for the 1996-1997 fiscal year and debts outstanding from prior fiscal years. Another $ 8 million was spent in the program's regular operations.

44. The Program was assigned $ 46.06 million for its 1997-1998 budget. The CHP anticipated that it would have a budget shortfall of approximately $ 6 million for the 1997-1998 fiscal year. Based on the anticipated 1997-1998 shortfall, the CHP prepared four analyses of its budget in an attempt to confront and deal with the contemplated shortfall.

45. As an example, one alternative proposed for dealing with the 1997-1998 budget shortfall would be to dismiss 20 regular employees. Furthermore, purchases would be reduced by 32 percent comprising of medical and surgical material; dental material; health education material; physical, occupational and recreational material; office and maintenance supplies; dental prosthesis and eyeglasses. In addition, the program would reduce by 15 percent the purchase of drugs and medicines, it would eliminate the purchase of medical and office equipment, reduce by 18 percent the general expenditures of the program and do away with the reserves of funds created to pay debts from previous years. The implementation of any one of the four alternatives to counterbalance the 1997-1998 budget shortfall would deal a severe blow to the delivery of health care services by CHP.

46. The budgetary difficulties faced by the CHP have not allowed the program to use its budget and fiscal processes as administrative and management instruments because the program has never been able to anticipate how much money it will have available. The program has no control over its budgetary and fiscal situation, much less the autonomy required to comply with the court's orders.

47. Since 1993, the services provided to inmates have increased. This increase necessarily results in higher costs to the CHP. As more inmates are seen by health care professionals, more lab tests are ordered and more illnesses and diseases are diagnosed and treated.

48. The problem of lack of funds which affects the CHP has diverted the attention of its personnel from

other administrative aspects of the program. The time spent addressing the funding problems has reduced the time available to attend to personnel and internal administrative matters. The CHP's staff does not know how, when or whether budget deficits are covered since this is an internal matter within AFASS's control.

49. Because of funding shortages, the CHP can only obtain special nutritional supplements for the most seriously ill patients. One of the Chief Health Care Coordinator's concerns in initiating a triple therapy program for HIV-positive patients in the AOC system is the lack of monies for medication and personnel. The CHP could have begun to provide triple therapy in 1996 if the concerns about budget, inmate tracking, and continuity of care had been addressed. The cost per patient of triple therapy is between $ 8,000 and $ 13,000 per year. Instituting triple therapy, however, can eventually save the Commonwealth money by reducing the number of patients that are hospitalized for opportunistic infections. The shortages and uncertainty in appropriations for the CHP make it difficult to contract with outside vendors since the program has to certify to them that funds are available to cover the expenses generated by any such contract. In addition, the program could not fill thirty staff positions needed to handle the administrative responsibilities associated with the execution of such contracts.

50. Administrative Order 112, together with Administrative Order 66, were intended to provide the CHP with greater autonomy in contracting and budgeting. Exhibit 379. Order 112 was intended to allow the CHP to transfer funds between line items in its budget. Administrative Order 112, however, did not fulfill the purposes for which it was promulgated

because the Correctional Health staff were not given contract numbers.[8] The CHP also could not exercise the budgetary autonomy intended by Administrative Order 112 because the program's staff did not have access to the Department of Health computers to transfer funds from one line to another. Thus, even when monies were available in the program's budget, the program may not be able to use them. [9]

51. The dissolution of the Anti-Addiction Services Department (DSCA, the Spanish acronym) and the creation of the Administration of Mental Health and Anti-Addiction services (ASSMCA, the Spanish acronym) created problems for the CHP because some former DSCA personnel were assigned to the CHP's mental health services program. Even so, the program was not assigned the additional financial resources to pay the salaries of those added persons or to provide anti-addiction services to inmates. Administrative Order 69, which transferred to the CHP the responsibility for providing services formerly provided by DSCA, established that all financial resources, personnel and equipment were to be transferred to the CHP. Although Administrative Order 69 required the CHP to provide mental health services for inmates with addictive disorders, the program was not assigned any budget for providing those services. In spite of the fact that both personnel and responsibility for anti-addiction services supposedly were transferred from DSCA to the CHP, the program never received the budgetary funds to correspond to the transfers. The only items actually transferred to the CHP from DSCA were some vehicles in very poor condition and some equipment.

Deficiencies in Staffing

52. The Correctional Health Program never has been able to recruit the number of health care staff required to provide adequate health care services to the AOC inmates. In particular, the number of staff personnel required to provide mental health services has never been enough. In some intake centers, where medical personnel are supposed to cover the admissions area 24 hours per day, CHP can only provide staff during the day and evening hours.

53. The Program does not have adequate control over its personnel administration. This lack of control has led directly to deficiencies in the delivery of health care services, and, in at least one instance, caused the death of an inmate. Arbitrary and unreasonable limitations on the program's ability to recruit personnel have been imposed on the program by the Secretary of Health and the Director of the Office of Management and Budget (OMB). For example, after the government privatized the Commonwealth's public health system, the Secretary of Health and the Director of the OMB instructed the CHP that it must first recruit new personnel from individuals formerly employed by the (Department of Health) DOH. It took several months for AFASS to deliver to the CHP a list of candidates who had been ceased from their employment with DOH as a result of the health reform. Even then, most of the candidates had no interest in working for the CHP.

54. Personnel in the CHP are grouped into four categories: employees who hold regular or permanent positions, transitory employees, wage earning employees--also called irregular employees--and contract employees. The law that created AFASS permits the recruitment of health professionals by contracts to provide medical services to the patients. Of

the four categories of personnel in the DOH, the irregular and contract categories are the least attractive to prospective staff because they do not include fringe benefits.[10]

55. Employees in the irregular category were recruited by the clinical services director at each institution and, once recruited, were officially appointed by the program's central office personnel division. As to the employees to be hired under contracts, the Chief Health Care Coordinator approved the recruitment of such employees subject to availability of funds. Once the potential employee is recruited, however, the award of a contract requires the processing of a number of documents. The contract processing procedure was originally performed by AFASS. Subsequently, the authority to process these contracts was transferred to the CHP although such contracts were still subject to AFASS' approval. Some of the documents that had to be compiled included a negative certification of debt from the Municipal Revenue Collection Center (CRIM, the Spanish acronym), the Department of the Treasury, and the Administration for Child Support Enforcement (ASUME, the Spanish acronym). This process could take months to complete. After the Court issued an order (at the joint request of plaintiffs and defendants) allowing the Chief Health Care Coordinator to process contracts, the process is presently completed in just a few days.

56. During the time that it takes to process a contract for professional services, the professional is not paid, even though he or she was performing services for the CHP. The CHP would compensate the professional by means of a "debt resolution." Under a debt resolution system, the actual payment is made

after a contract is approved. The executive director of AFASS can approve a debt resolution up to a certain amount but beyond that amount, it must be approved by the Secretary of Health. Currently, however, the executive director of AFASS is the Secretary of Health. Typically, in agencies other than the DOH, a debt resolution is used to pay for services rendered on a one-time basis, where there is no contract. If a contract is being processed, then the agency does not issue debt resolutions. Initially, payment by debt resolution was made during the time that contracts were pending at AFASS, but later, the process was changed so that debt resolutions were issued only after the contract was approved. The Secretary of Health, however, has tried to limit the use of debt resolutions. In effect, this leaves the CHP in a difficult situation because it cannot offer contract employees immediate pay while contracts are pending, but it cannot offer them debt resolutions either. See Exhibits 179-198, 227-237. In July 1995, AFASS notified the CHP that it no longer would pay contract professionals whose contracts were pending renewal until after the contract was renewed. Under this arrangement professionals had to work for extended periods of time without being paid. Exhibits 228, 229.

57. Prior to August 1996, doctors on duty were paid $ 18 per hour, and it was extremely difficult to get anyone to work for that money. Beginning approximately in August 1996, doctors on duty were paid $ 22 an hour from Monday to Friday night and $ 25 an hour on weekends and holidays. This modest raise has not resolved the problems of recruiting doctors to work at night and on weekends because at medical facilities covered by the health reform, night and

weekend shifts are paid $ 30 to $ 35 an hour. In June of 1996 and June of 1997, many professionals under contract positions resigned because the money they were paid was too low and because the facilities were grossly inadequate.

58. The CHP cannot pay per diem and mileage to the doctors on duty. In 1996 the CHP paid mileage to the personnel under contract but was not authorized to pay per diem.

59. The large number of transitory employees and regular positions in the CHP has resulted in instability within the work place. The transitory positions offer some measure of stability, but those positions tend to be extended after expiration of the initial term on a month-to-month basis, offering the employees little assurance that their positions will remain available in the long term.

60. The CHP can offer no incentives for the economic betterment of its personnel. The CHP cannot provide any economic incentives to reward good work or merit. Contract personnel in the CHP have no fringe benefits except for mileage. The bureaucratic and budgetary obstacles to recruiting and retaining qualified personnel result in a loss of motivation among the personnel. Correctional Health professional staff complain that the personnel system is too complicated and bureaucratic. The budgetary and bureaucratic obstacles to recruiting and retaining professional staff negatively affect the ability of the administrators of the CHP to monitor the quality of services delivered to the penal population. The CHP cannot recruit the necessary staff it needs to operate efficiently because the difference in the budget appropriated to the

program in relation to the actual payroll expenses of the program in previous years is inadequate.

61. The number of regular employees increased between March 1996 and June 1997 as a result of a law passed in 1996 that granted regular status in permanent positions to certain transitory employees. Exhibit 543. The CHP experienced substantial instability in staffing levels during the period from April 1995 through June 1997. Exhibit 590. The CHP experienced a substantial decrease in recruitment, and a consequential decrease in staffing levels, in June 1996 after the adoption of Law 150. This law established a two-year waiting period before a person who had worked for the government could be re-hired into government service. Furthermore, the Program's recruitment efforts declined in September, October, November, and December 1996 because of the electoral law's prohibition on hiring personnel for sixty days before and after a general election. Exhibits 590, 545.[11] A precipitous decline in recruitment was experienced by the CHP in June 1995 because a hiring freeze was implemented at the Department of Health. Exhibits 590, 545. The CHP experienced a decline in the number of registered nurses employed by the program in May and June of 1996. The program recovered from the decline following July 1996 after the promulgation of Administrative Order 112, but experienced another decline after February 1997 because the prohibition on hiring imposed by the electoral law in the months following the 1996 election ended and nurses started seeking employment with other governmental agencies. Exhibits 547, 595, 596. The experience of the CHP in recruiting and retaining registered nurses during 1995, 1996, and 1997 was very disheartening.

62. In August 1997, the CHP could not hire nurses for Camp La Pica because of budgetary shortfalls. The shortage of nurses at La Pica had to be covered by transferring nurses from the Ponce correctional facilities. It became very difficult at times to effectuate said transfer due to the resistance and protests of the nurses selected to be transferred to La Pica.

63. The CHP is not complying with the Medical and Mental Health Plans in part due to the difficulties it faces hiring and retaining personnel. Said difficulties are caused by factors foreign to the functioning of the Program.

64. A serious setback in the ability of the CHP to recruit qualified professional personnel occurred in 1995 when the Government Ethics Law was amended to mandate a two-year prohibition or waiting period before awarding employment contracts to persons who formerly held civil service positions with the government. This amendment, knows as Law 150, created problems for the CHP because one of the sources available to it for recruitment of health professionals comprised those individuals who had just completed a mandatory one-year public service requirement. These persons were considered "civil servants" under the statute, and thus were subject to the two-year waiting period. It was possible depending on the circumstances to obtain a waiver from said prohibition. The waiver had to be obtained from either the Government Ethics Office or the Central Office of Personnel Administration (OCAP, the Spanish acronym). The delays confronted in obtaining a waiver, in most cases, was too costly to significantly improve recruitment.

65. Unfortunately, OCAP and the Government's Ethics Office (OEG, the Spanish acronym) had conflicting interpretations of Law 150. OCAP was of the opinion that the mandatory year of public service did not fall within Law 150. The OEG not only concluded otherwise, but also insisted that OCAP had not authority to interpret Law 150 in such cases. In addition, the OEG opined that a person who had obtained a waiver from the application of Law 150 was required to apply for a second waiver when that person's contract was renewed, even if there was no change in the substantive terms of the original contract. Following the entry of the Court's order of May 16, 1997, the CHP ceased requiring waivers for persons who already had obtained a waiver but whose contracts were up for renewal. The CHP, nevertheless, was not able to recover from the detrimental effects of Law 150 on its recruitment efforts. As a result of the passage of Law 150, the CHP lost 14 professionals because that were not granted waivers. These included general practitioners, psychologists, dentists, occupational therapy assistants, physical education teachers, and medical coordinators.[12] The defendants have not shown that any effort was made to solve these bureaucratic conflicts in spite of the dire consequences which they directly caused to the quality of the health care provided to the members of plaintiffs' class.

66. The CHP attempted to fill positions with independent contractors because the program could not offer salaries to professionals for permanent employment positions that were competitive with private sector opportunities. By offering them contracts instead of permanent employment positions the program was able to offer higher salaries. Although

this practice is fairly common throughout the Department of Health since the department's salary scales are too low to attract qualified professionals for employment, the CHP was not very successful in its efforts to recruit personnel.

67. The CHP began to develop a personnel office in 1994. The creation of a personnel office within the CHP was authorized by Administrative Order No. 66 of June 3, 1993, which also allowed the program to appoint employees and to contract for professional services. The CHP began to recruit personnel in April 1994 until July 1994, at which time it had to suspend recruitment because of a June 1994 moratorium on hiring at the Department of Health. The moratorium on hiring declared in June 1994 continues in effect as to permanent positions and irregular positions, but the CHP has managed to hire professionals as independent contractors. The program also had to seek the intervention of the Governor's Personal Representative to cover positions at the Ponce Complex when that complex became an intake center. Even though the program obtained the requested assistance, there was considerable delay in staffing the intake center.

68. A second Administrative Order, Number 112, issued in July 1996, delegated further authority to the CHP in making hiring decisions. The program's ability to make use of the authority granted by Administrative Orders 66 and 112 has been curtailed by a number of hiring moratoria. The Secretary of Health insisted that all irregular appointments required the approval of the deputy director of AFASS. This requisite meant that the delegation under Administrative Order 66 had little effect. Nevertheless, the CHP experienced a substantial increase in staffing levels during the months

following July 1996, when Administrative Order 112 delegated to the program's newly created personnel office the authority to create transitory positions.

69. Although the June 1994 moratorium continued in effect, it was conditionally lifted in October 1994 to allow the program to fill regular positions, provided that such positions were first to be offered to qualified DOH employees who had been displaced by the privatization of health services and by persons referred to CHP by the Right to Employment Administration. If no personnel was available from these two sources, then the CHP was permitted to recruit from outside the DOH. Only if the Deputy Secretary of Health issued a written certification that there were no candidates available under the health reform, could the program recruit from other sources. The requirement that the CHP recruit from among DOH employees displaced by the health reform led to a number of problems. For example, the Secretary of Health transferred a number of displaced DOH employees to the CHP without first notifying the CHP's central office. In addition, the Executive Director of the CHP made a number of attempts to obtain a list of available personnel displaced by the health reform, but the list was not provided until late 1994, several months after the directive was issued. Until then the CHP continued recruiting personnel from the other sources up to December 1994. It was then that the Secretary of Health announced that all irregular appointments had to be submitted for approval to the deputy director of AFASS. The CHP made numerous efforts to recruit DOH personnel displaced by the health reform from 1994 through 1997, but many of the candidates that were available did not want to work in the prisons. A

large number of them did not even show up for interviews with the institutional medical directors.

70. The CHP has been losing ground steadily since 1996 in recruiting and retaining personnel. During 1997, the program lost the executive director, its director of mental health services, the director of the psychology section, the pharmacy director, and the director of the control of infectious diseases (who was replaced in July 1997). In 1996 the program lost its engineer, its director of quality improvement, its director of dental services, and previously in 1995, the program lost its personnel director. With the exception of the director of the area of infectious disease control, the program has not been able to replace any of the other directors it has lost. The program suffers from a high rate of turnover, which currently stands at the rate of 50% throughout the system. This high rate of turnover affects proportionately, in negative way, the continuity of care provided to patients in the institutions. The conditions at the physical facilities of the AOC institutions have made it difficult to recruit personnel. Another difficulty when recruiting personnel is the fear that prospective recruits have to work in a prison setting. At times, the CHP has had to stop recruitment because of budgetary difficulties. At other times, the program has had the budget, but there were no candidates available. Still at other times the budget has been available and candidates have been recruited, but because of some bureaucratic impediment, they were not hired.

71. It is impossible to cover every aspect of health care delivery when the program suffers from shortages of key personnel. The shortage of CHP staff at the institutional level has severe consequences on the ability to provide health care to inmates. For example,

the effect of the amendment to the Government Ethics Law (Law 150) meant that admission services were curtailed or eliminated at some institutions, resulting in numerous inmates with undetected health conditions entering the prison system.

72. Other factors which impact on staff retention are the frustration that the personnel feel when they are not able to move the Program towards greater compliance with the court's orders; the difficulty in replacing lost personnel because it cannot compete with the private sector in terms of salary and benefits; the crowded and inadequate facilities where the health services are provided; and the lack of adequate equipment.

73. It may take six to eight months to fully train CHP staff before they become familiarized with the institutions and the Program's policies. Each time the Program loses personnel this represents a loss of a significant investment in time and resources even if the person leaving is immediately replaced.

74. The dedication and quality of the CHP personnel are simply not enough of a driving force to continue to improve the correctional health services offered. People can burn out, which in turn, causes the fragile system that is in place to collapse.

75. The CHP also lacks the necessary staff to cover the infectious disease program at the central level. In particular, the program lacks a statistician. The absence of staff in this area means that certain duties that need to be performed by specially trained staff are carried by other health care staff.

76. One specific area of great concern to the court is the decline in the mental health staffing levels. It is

very difficult to find mental health providers who want to work in a correctional environment. The problem exists at both the retention and recruiting stages. The requisite staffing levels for the mental health care component of the CHP were established as a result of a mental health staffing plan that was developed after the Mental Health Plan was adopted. Since that time the demand for mental health staff has increased in the AOC, in part, because of an increase in the inmate population, and also because of an increase in the number of acute psychiatric cases being admitted from the free community.[13] Statistics for the program show that after a marked improvement in staffing in the types of mental health provided between 1993 and 1996, these fell overall during the 1996-1997 fiscal year. The reasons encountered in recruiting personnel to provide mental health services are two-fold: first, most mental health professionals gravitate to the San Juan area, thereby reducing the number of potential candidates for facilities outside of the metropolitan area; second, the CHP cannot compete with the private sector, with ASSMCA, or with the health reform, since the program cannot offer competitive salaries or fringe benefits.

77. The program has taken steps to expand the amount of coverage provided with the short numbers of staff it has, but even so, not all areas are covered. For example, to cover the shortage of psychologists providing admission services, CHP personnel are in the admissions areas from 8:00 a.m. to 11:00 p.m. The Mental Health Plan requires that admission areas be staffed 24 hours per day. Similar measures are taken anent emergency areas. The shortage of personnel at the Sabana Hoyos Correctional Institution for approximately three months prior to September 1997

was so acute that the CHP was not able to provide full-time admissions or emergency areas coverage.

78. The CHP cannot provide on-call physicians to cover emergency services at smaller institutions. The Comptroller of Puerto Rico has concluded that it is illegal to pay on-call physicians that are not on-site during the time that they are on-call. Nevertheless, using on-call physicians to cover emergency needs is standard medical procedure. (This is the single instance of a stumbling block that the court can find that does not originate with the defendants. The Comptroller is an autonomous entity. The defendants, however, did nothing to challenge the Comptroller's ruling.)

79. The CHP has only 50 percent of the dentists it needs. It is difficult to recruit dentists because the Commonwealth's health reform program includes very generous dental care coverage, which means that dentists can make substantially more money in the private sector than at the CHP. As explained elsewhere in these findings, dentists (as well as other CHP personnel) also are difficult to recruit because of inadequate facilities, supplies and equipment.

80. In spite of significant improvements in health education, the CHP still does not have a sufficient number of health educators to train correctional officers and for in-service training of health personnel. The program requires six or seven more health educators.

Personnel Problems at the Three Main Correctional Complexes[14]

81. The CHP is plagued by a high turnover of physicians and shortages of staff at the institutional level. The admissions area at the State Penitentiary complex in Rio Piedras suffers from a lack of

physicians. On many occasions there are no physicians on duty during the night hours. The constant resignation of the doctors ascribed to the admissions area of the Rio Piedras complex detrimentally affects the completion of the inmates' intake health evaluations. In 1995, the completion of intake evaluations within seven days of admission was 30.6%; by 1996, this rate had increased to 90%. After May 1996, however, the rate dropped to around 50%. The recruitment of physicians for the Rio Piedras complex is very difficult. Employment under contract is not attractive to physicians because there are no fringe benefits available. Until recently, physicians who had just completed the required year of public service were ineligible to work for CHP by contract because of recent amendments to government ethics statutes. Another factor that affects negatively the recruitment of physicians is the risk factor of working within a prison setting. The program cannot offer sufficient incentives to compete with the private sector in the recruitment of psychiatrists at the Rio Piedras complex.

82. Admission services available at night and during the weekends at the Ponce Complex are staffed with physician, nurses, and medical record personnel until 11:00 p.m., although admission services should be staffed 24 hours per day. The recruitment of personnel for night duty is made by professional service contracts. The CHP has encountered problems recruiting personnel for the Ponce Complex because of competition from the private sector and from the health reform. As a result of the health reform carried out in the municipalities near Ponce there exist job opportunities for physicians offering better salaries,

working conditions, and personal security than those offered at the Ponce complex. The complex does not have a gynecologist or obstetrician for the women's facility. The chronic care clinic for young adults and the women's facility is staffed with a family medicine practitioner. The lack of physicians for the complex as a whole results in only 2 percent of the population having access to sick call services. At least three or four more physicians are needed, especially in the maximum security area, where two physicians are required to cover sick call. Currently, only one is available and there have been months when no physicians were available. The dispersion of medical services throughout the complex stretches to its limits the personnel that are available, whereas centralization of these services would result in a more efficient use of available personnel. The complex is short of dentists. The young adults intermediate psychiatric care unit is staffed with a director (who is a social worker) and a psychiatrist during Saturdays. The shortages of personnel affect the delivery of care to the patients and also makes it difficult to retain the personnel, who leave as they become frustrated as a result of said shortages. Only one psychiatrist, who works 120 hours a month, is assigned to cover the ambulatory services plus the admission patient referrals at Ponce Main, young adults, women, and Ponce Maximum. Another psychiatrist, who works 40 hours per month, divides his time between the two intermediate care modules at the complex.

83. The Bayamon facility also suffers from a lack of personnel. The admission process at the Bayamon complex never has been carried out in a continuous fashion because of a lack of physicians to perform the

admission examinations. Part of the difficulty in recruiting personnel is the scarcity of X-ray services. Doctors have refused employment at Bayamon because they cannot count on the use of X-rays as a diagnostic tool in completing evaluations. Other factors which contribute to the difficulty of recruiting health personnel at Bayamon is the lack of security and the great number of patients needing medical treatment. One of the tactics used by CHP personnel to cover admission services is assigning off-duty physicians to night duty. Thus, some physicians at the complex in effect work 80-hour weeks. Some of the physicians have threatened to resign because of the stress this places on them.

84. The Rio Piedras complex lost one of its two X-ray technicians in October 1995. The remaining technician was not sufficient to cover the demand generated by new admissions. Although a second technician finally was recruited in July 1997, the two that are presently there are not sufficient to cover all shifts.

Additional Personnel Insufficiencies

85. The CHP does not have an ophthalmologist.

86. Additional staff will be necessary to properly administer triple therapy treatment for HIV patients. In particular, physicians who specialize in infectious diseases must perform the initial evaluations and the initial follow-ups for such patients in order to design the optimal treatment plan. The infectious disease specialists also should perform periodic supervision of the treatment these patients are receiving.

87. In spite of the difficulties in finding and retaining qualified staff, the persons that the CHP does manage

to recruit are highly competent and extremely committed to the process of providing correctional health care services. Those who testified at the hearing however, made it abundantly clear that they cannot hold out much longer under the present circumstances and that some drastic changes must occur. Although the various medical directors testified about their personal experiences, they also stated that many other health care personnel under their supervision felt the same way.

Employee Discipline

88. By virtue of Administrative Order 66, the CHP's personnel office commenced filing for disciplinary proceedings against CHP staff with AFASS but no action was forthcoming. In early 1995, the director of the personnel office of the CHP visited AFASS to inquire as to the status of the disciplinary cases referred to it and was told that AFASS had too much work and too many disciplinary cases from the Department of Health. It was then that the Chief Health Care Coordinator requested permission from the Secretary of Health to contract a lawyer to process the disciplinary cases. Although authorization was granted, the CHP encountered numerous obstacles anent the attorney's contract. After having rendered services for some time, the contract for the attorney retained by the CHP to process the disciplinary cases was not renewed and another attorney, chosen by the legal division of the Department of Health, but paid for from the Program's budget, was assigned. The attorney selected by the Department of Health's legal division to process disciplinary cases for the CHP was completely unfavorable to the program. In January 1997, the Secretary of Health peremptorily ordered the

immediate cessation of legal services for disciplinary matters and ordered the CHP to contact the services of a private law firm.

89. The disciplinary actions processed by the CHP through AFASS involved permanent employees and those transitory employees with an expectation of a contract lasting more than one year. There are several reasons why an efficient employee disciplinary program is important, including deterring employees from infractions of the rules, thus ensuring order in the functioning of the program. The inefficiency in processing disciplinary matters in the CHP threatens these goals. For example, in early 1996, a number of CHP staff participated in an illegal strike at the Rio Piedras Complex. Although AFASS was asked to take disciplinary action against these employees, six months later nothing had been done. One CHP employee was the subject of numerous complaints at the Arecibo District Jail in 1996. The Secretary of Health was asked to take some action against the employee, but almost nine months later, the Secretary still had not responded to the request. In early 1995, the Chief Health Care Coordinator requested the assistance of the Secretary of Health in dismissing a problematic CHP employee, but almost two years later the situation remained unresolved.

90. Disciplinary action is ineffective because cases are not energetically and promptly prosecuted. For example, the program currently has 52 disciplinary cases that have been pending between two to three years at different levels in the process of adjudication. It can take months to prepare a disciplinary case for presentation to the Secretary of Health for action. Then, the disciplinary regulations which cover the CHP

staff are general regulations developed for AFASS and the DOH and do not take into consideration the particular concerns relevant to a correctional setting such as security. Because the disciplinary regulations which apply to CHP staff are not geared to a correctional setting, the program does not have the tools that would facilitate the enforcement of adequate discipline measures in the correctional setting. The absence of a prompt and effective disciplinary system for CHP staff lowers the morale of those that do not violate the regulations. They come to feel that the system has a greater concern for those who do not comply with applicable norms than for those that do.

Facilities

91. Admission into the Puerto Rico prison system currently is done through the Bayamon, Ponce, and Rio Piedras Complexes, and at the Vega Alta and Sabana Hoyos correctional institutions.

92. Among the weaknesses identified during the strategic evaluation performed in 1996 was the inadequacy of the physical facilities available for providing correctional health services. Crowded, unsecure and inadequate physical facilities is one of the factors making it difficult to hire and retain health care personnel. The physical setting in which health care is provided in the AOC system affects the ability of specialists in various disciplines to work together, particularly in the larger institutions, where services are scattered among different buildings. This is especially true in Rio Piedras, Bayamon, and Ponce, where the scattering of services makes supervision almost impossible. Insufficient clinical space at the

prisons also has made it difficult to provide subspecialty clinics on-site.

93. Acute mental health care for inmates is provided at the Correctional Psychiatric Hospital, which opened in August 1996. Only one of the three modules--which module has 54 beds--is currently in use. The criteria for psychiatric hospitalization is acute decompensation exhibiting psychotic symptomatology, suicidal ideation and severe depression, or drug addiction-related symptomatology with psychiatric decompensation.

94. During an outreach performed by Correctional Health staff in 1997, 17 inmates were identified as requiring hospitalization, yet only 11 of these inmates could be hospitalized for lack of psychiatric hospital beds. Some of these inmates have been waiting two to three months for a bed in the hospital. Optimally, when a patient is diagnosed as requiring psychiatric hospitalization, the patient should be immediately hospitalized. The Correctional Psychiatric Hospital remains partially open because the AOC cannot provide the 45 correctional officer needed to provide security for the hospital.

95. The CHP also does not have sufficient PICU (psychiatric intensive care unit) beds for the number of patients who require that level of care. The Plans require a total of 25 beds for emergency mental health care in the Puerto Rico prison system. Currently, the system has only 20 beds for emergency mental health care: 14 at Rio Piedras, 2 at Ponce, and 4 at Vega Alta. None of the other intake centers have emergency mental health care beds. The PICU at the Rio Piedras complex must serve all of the male institutions on the island because the Ponce facility, with only two beds, is

not sufficient. Consolidating emergency mental health care services at the Correctional Psychiatric Hospital would allow the CHP to render better services to the inmate population. Because of the unavailability of physical facilities generally for correctional health services, the PICU area also houses the offices of the regional epidemiologist, the health services coordinator for the Rio Piedras complex, two health educators, and two other staff persons not directly related with the mental health care services.

96. There is also an acute shortage of medical dormitory beds. There are only 32 medical dormitory beds currently in use; these are located at the Rio Piedras State Penitentiary, which means that only pre-trial detainees can be housed there. Ten medical dormitory beds at Annex 504 have been unavailable for a year and a half because of reconstruction work performed under the Facilities Rehabilitation Program. Although there is an area designated as a medical dormitory at the Bayamon Complex, the AOC places inmates in that area that do not require health care services. There used to be 25 beds at Ponce Main designated as a medical dormitory, but the AOC requested use of the beds for non-health care purposes in 1995. The AOC has never returned those beds to be used for medical purposes only. There is no medical dormitory (or infirmary) at the Sabana Hoyos Correctional institution, nor is there an intermediate psychiatric facility there. There used to be nine medical dormitory beds at Guayama, but the area where those beds are located is also under repairs. Finally, there are 24 medical dormitory beds at Ponce Maximum, but the beds originally were designed to be used as segregation beds, and inmates who are assigned to that medical

dormitory refuse to go there thereby jeopardizing their health.

97. The CHP is not in compliance with the standards for provision of chronic illness care, in part because of the shortage of chronic care beds. Moreover, the program cannot control which inmates are assigned to beds in medical dormitories, and the AOC indiscriminately assigns inmates who do not require chronic care to those beds. The AOC simply has no system for determining whether an inmate meets medical criteria for placement in medical dormitories or intermediate psychiatric units.

98. In addition to using medical dormitory beds for non-medical purposes, the AOC also has used intermediate psychiatry beds for non-medical uses. Although infirmary beds are not included in the census of the AOC general population, medical dormitory beds are included. It would assist the CHP in administering its responsibilities if medical dormitories and intermediate psychiatric beds were excluded from the inventory of beds counted for crowding purposes. The inclusion of these extended care beds in the general population inventory places pressure on the AOC to use the beds for non-health care purposes.

99. The prison system in Puerto Rico also lacks isolation facilities. In order to effectively deal with infectious diseases, the CHP requires protective isolation and respiratory isolation facilities to control outbreaks of diseases like tuberculosis, as well as to comply with OSHA regulations. Isolation rooms should be checked at least every month and the air changes in the rooms should be monitored. Failure of the isolation rooms to work correctly increases the probability of an

outbreak of disease among inmates and staff. The infirmary at the Rio Piedras complex does have three isolation rooms, but these facilities cannot be used for that purpose because they lack the special equipment required to minimize the risk of spreading diseases to the personnel in the infirmary. In particular, the rooms lack ultra violet lamps, which have never been installed, and the split unit air conditioners and retractors are not functioning. The Ponce Complex also has two isolation rooms in the main institution and four in the maximum security infirmary but they have never been used because the ventilation systems required for such rooms were never installed.

100. The physical facilities on the first and second floors of the hospital at the Rio Piedras Complex are unsuitable for their intended purpose. The dental area is very small and more chairs are needed in order to render services to more patients at the same time. Also, there are only two holding cells on the first floor and two on the second floor to keep the inmates awaiting their medical appointments. Each cell holds ten inmates. These are not large enough for the number of patients seen at the hospital. Also, when inmates from different institutions are brought to the clinics, they must be separated from each other for security reasons. Thus, the clinics cannot be used to their full capacity.

101. Both the medical records area and the pharmacy area at the Rio Piedras complex are overcrowded, a deficiency pointed out by both the Occupational Safety and Health Administration and the Department of Health. The Department of Health also found numerous other deficiencies during an inspection of the State Penitentiary hospital. For example, the alarm system was broken, warehouses were without

smoke detectors, cockroaches were found in different areas, water leak marks on the ceiling and bio-medical waste was improperly stored in a room beside the laboratory. Because of these deficiencies, the accreditation of the hospital at the time of the hearing was in jeopardy. If the Department of Health withdraws the accreditation of the hospital, the ensuing reduction in services would detrimentally affect the entire inmate population.

102. A shortage of beds at the detox area and in the infirmary at the Rio Piedras complex makes it impossible to place all inmates suffering from withdrawal symptoms in those areas. Inmates suffering from withdrawal symptoms must therefore be provided treatment through ambulatory services. This situation impacts their health significantly. This same problem exists at the Ponce Complex, which has only 13 infirmary beds. Of approximately 150 admissions to the infirmary each month, around 135 of the patients are suffering from withdrawal symptoms. The shortage of beds means that many of these withdrawal patients must be treated through ambulatory services. This type of treatment is dangerous because such patients suffer from dehydration, blood pressure problems, cardiac problems, mental problems such as change of personality, and they require constant supervision. The Bayamon Complex also suffers from a shortage of infirmary beds with the same attendant problems.

103. The San Juan Correctional Institution, also known as Annex 504 or "Las Malvinas", has two modules that serve as intermediate psychiatric services modules. Mental health patients housed in the intermediate care modules suffer from severe chronic mental conditions and require continuous supervision in

order to perform their everyday tasks. These modules at Annex 504 in Rio Piedras lack nurses' stations and are located far away from the interdisciplinary team that serves these patients. Thus, the Correctional Health staff rely on custodial officers to escort them into the modules. Because of a constant unavailability of custodial officers, however, the opportunities to provide medical services to inmates in the intermediate care modules are limited. The intermediate care area also suffers from lack of water, which results in unsanitary conditions.

104. The absence of water in the higher floors of the State Penitentiary and Annex 504 diminishes the willingness of inmates to attend clinics and sick call because they cannot bathe or shave. Also, when there is no water in the hospital at the Rio Piedras complex, the dental clinics have to be suspended.

105. The Correctional Health facilities at Ponce Main and Ponce Maximum have problems with the air conditioning system each summer. The intermediate psychiatric services areas at the Ponce Complex also suffer from electrical problems which affect the continuity of services to the inmates.

106. The Bayamon Complex also has inadequate physical facilities. For example, dental services must be provided in the same place where sick call and internal medicine clinics are carried out. The number of services rendered results in an enormous volume of patients in a small area. At Bayamon 448, there is no work-space for nursing and medical personnel, thus, the only service rendered at that facility is the delivery of medication. Patients must be taken to Bayamon 308 for treatment and examination. The medical dormitory at Bayamon

1072 lacks the most fundamental amenities of a medical dormitory. There are no ramps for handicapped patients, there is no hot water, and there are no facilities to perform medical examinations within the unit. Although the medical dormitory has a capacity of 36 patients, the AOC houses inmates in the module for security or disciplinary reasons, thus reducing the number of patients who can be housed there for medical reasons. These problems affect not only the health of the medical patients but also their safety. At times, the number of disciplinary cases in the medical dormitory has equaled the number of medical cases. The Bayamon facilities suffer from a lack of adequate sanitation and bathing facilities and a lack of hot water. While undergoing intake evaluation, inmates at Bayamon are housed in dilapidated and unsanitary conditions which the Court personally inspected, along with counsel for the parties.

107. Medical facilities at the Sabana Hoyos Correctional Institution are inadequate, both in terms of space and because the equipment is old and outdated.

108. The lack of space and equipment compromises the medical care provided. In Rio Piedras, the lack of space results in a number of inmates answering health staff's questions in close proximity to each other, thus compromising confidentiality and security.

109. CHP staff have identified 26 patients in the AOC system with antisocial personality disorders, who exhibit symptomatology, at times, of self mutilation, acute brief psychotic episodes or suicidal attempts or gestures. Those patients are extremely disruptive within the system and exhibit highly abusive behavior toward other inmates. Although the CHCC has

requested that 26 to 30 beds be designated for these inmates from several AOC administrators, none of them have responded to the requests.

110. The only physical therapy clinic and optometry clinic in the AOC system are located at the Rio Piedras Complex. These clinics serve all of the institutions on the island, including patients from privatized institutions. Inmates incarcerated near Rio Piedras have more access to the optometry clinic than do inmates located farther from Rio Piedras. This is also true for physical therapy clinic. There is only one physical therapist and one optometrist to serve the entire inmate population on the Island. The Rio Piedras complex does not have a physiatrist to make referrals to physical therapy. The complex depends on referrals to the Medical Center in Rio Piedras.

111. During the intake process at the Rio Piedras complex, prisoners receive services at the infirmary and at the PICU. Patients at the different out-patient clinics also receive services at the hospital, located adjacent to the State Penitentiary. All chest X-rays that are ordered at the complex are taken at the hospital. The inmates who are going through the admissions process are housed in modules A-2 and C-2, each with a capacity for 14 inmates, and in modules B-1 and C-1, each with a capacity for 75 inmates. This commingling of inmates and functions in substandard physical facilities delays or impedes the delivery of health care services, causes health hazards, and creates serious unacceptable security conditions.

112. The medical area at the State Penitentiary has only one holding cell with capacity for 10 inmates. This affects the admission process because only ten inmates

at a time are allowed to wait their turn for medical evaluations. If more than ten inmates require evaluations, they may not all be seen immediately.

113. The AOC is housing inmates in the admissions area at the Ponce complex even though the inmates are not admission cases since there is no space in the general population cells to house these inmates. The AOC promised the Court that the inmates would be moved. However, they assigned numbers to three cells to use them to expand the housing capacity. This leaves the admissions area with only two cells and a reduced space where newly admitted inmates can be held. This also promotes mixing of newly admitted inmates with general population inmates. At Ponce Main, patients wait to be processed for admission first at the AOC holding cells and then at the Ponce Main holding cells. There are five holding cells at Ponce Main; each has a capacity from 12 to 15 inmates. When these holding cells are overcrowded, the AOC uses the holding cells in the medical area. Sometimes the AOC houses inmates in the medical area's holding cells for four to five days. There is only one bathroom for the five cells and occasionally only one officer to supervise them.

114. Because newly admitted inmates and general population inmates are mixed in the admissions area, inmates from different gangs sometimes come into contact with each other, which creates substantial security problems. Thus, the security of staff and patients is compromised.

115. On the first floor of Ponce Max is an emergency room area and a dental services area. There also is a medical dormitory where inmates with chronic diseases, paraplegics, and persons with physical

impediments are housed. The Ponce Max medical dormitory serves the entire Ponce Complex, as well as all the institutions in the southern region of Puerto Rico, including Fort Allen, La Pica, Guayama, and occasionally Mayaguez, located on the West coast of Puerto Rico, and Sabana Hoyos, located in the Northwest part of the Island.

116. In Bayamon, the admissions services are integrated with other medical services. The admission process is carried out in the same place and at the same time as dental, pharmaceutical, internal medicine, and chronic services. Because of the mixing of all these services at the same time and in the same place, inmates from different gangs may come into contact with each other, which results in security problems for the inmates and the medical personnel.

117. Dental services at the Bayamon Complex are offered at Bayamon 308, which also covers dental patients from Bayamon 448. Dental services are offered at Bayamon 1072, where patients from Bayamon 292 also are served. There are no X-ray services available in these areas. The dental services at Bayamon 1072 are rendered in the same area where the delivery of medications and sick call and all internal medicine clinics are carried out. Because so many services are rendered in the same area, the volume of patients is enormous. Because there usually is only one officer available, the medical services director must at times order the suspension of dental services at Bayamon 1072.

118. The medical services provided at Bayamon 1072 are dental, sick call, and internal medicine services. Bayamon 1072 is the only area in the entire complex

where emergency services are rendered, together with hospitalization services, infirmary services, and psychosocial intermediate services.

Equipment and Supplies

119. Because AFASS fails to pay suppliers, the CHP has not received medical supplies, such as gloves, disposal gowns, office materials, eyeglasses prescribed by the optometrist, and X-ray film. Lack of equipment at some institutions hampers the completion of intake health evaluations.

120. The lack of supplies in the emergency area at the State Penitentiary hospital hampers efforts to provide emergency services. The Bayamon Complex also suffers from a shortage of emergency room equipment. The emergency area at the Ponce Complex has only one gurney.

121. Two years ago an X-ray machine was purchased for the Sabana Hoyos Correctional Institution. Because that institution did not have the appropriate physical facilities in which to install the machine it was sent to the Rio Piedras complex, where it was to be installed in the admissions area of the State Penitentiary. The installation of this machine would avoid the problem of transporting newly-admitted inmates at the State Penitentiary to the hospital for chest X-rays. The machine remained in storage for two years, and when it was finally installed in the admissions area, other facilities, however, necessary to use the machine--a dark room, correct lighting and electrical equipment--were not prepared. At the Rio Piedras complex, there also are shortages of X-ray film.

122. The CHP also suffers from lack of supplies and materials at the central office level. The infection

control program at the CHP does not have the computer equipment necessary to perform its functions. The program suffers from a lack of functioning vehicles, which are necessary to ferry personnel, communications, and supplies between the institutions and the central office and among the institutions.[15] The infectology program cannot perform its job because statistics must be compiled by hand and the CHP does not have an effective inmate tracking system. This results in a very inefficient and too slow a process which is not of much use to the CHP. The infection control program is not complying with current professional standards of medical treatment because of the difficulty of obtaining accurate statistics. The incompleteness of the infection control program results in an increased risk to the inmate population because the lack of information hinders early treatment of diseases. Moreover, the lack of information makes it difficult for the infectious disease program to make accurate recommendations concerning the control of infectious diseases in the AOC system. The spread of opportunistic infections in AOC institutions can affect staff members as well as inmates, if those staff have compromised immune systems.

123. The lack of ambulances is a widespread problem throughout the AOC system. Although the AOC purchased ambulances for every institution approximately two and a half years ago, the purchase has not resolved the shortage of ambulances because the AOC does not follow the guidelines for using the ambulances that were established by the CHP and signed by the Administrator of the AOC. It took two years for the AOC to forward to the CHP a list of

correctional officers who are qualified to drive the ambulances.

Non-Performance by the Administration of Correction

124. Conditions in some medical dormitories--which are controlled by the AOC-are so bad that inmates in need of treatment refuse to be placed in them, especially when the dormitories are used also to house dangerous or aggressive prisoners. Because inmates refuse to be placed in medical dormitories, and instead reside in the general population, chronically ill inmates who require constant supervision do not receive that supervision and their health is thus endangered.

125. The AOC is also unable to transport inmates to offsite medical appointments. Although the CHP staff is able to obtain appointments for inmates at offsite specialty clinics, AOC staff have been almost uniformly unable or unwilling to take inmates to those appointments. The AOC does not have sufficient vehicles or staff for security or transportation purposes.

126. The Administration persistently transfers inmates from one institution to another without the inmates' files being reviewed by CHP personnel to determine whether the inmates' medical needs can be met at the institution to which the inmate is transferred. Not all institutions offer the same level of care. It would be inefficient and prohibitively expensive to offer the same range of services at all institutions. Thus, the CHP offers greater levels of medical coverage at some institutions than at others. In terms of the placement of inmates, those who suffer from certain medical conditions cannot be transferred to just any institution. For this reason, prior to transferring an

inmate, the AOC must first consult with CHP staff to determine if there are medical contraindications for the transfer. The AOC routinely ignores this requirement. In addition, inmates are frequently transferred without their medical files. This represents an unwarranted danger to the health of the inmate if he or she requires a level of medical care that is not available at the new institution.

127. In addition to lack of facilities in AOC institutions, the inability or unwillingness of the AOC to staff the Correctional Psychiatric Hospital together with the history of deficiencies in the budget have prevented the CHP at present from using all of the beds that are available in that facility. Under an agreement between the AOC and the Department of Health, the Correctional Psychiatric Hospital is administered by the CHP, but security and custody are provided by the AOC (the facility houses and treats inmates under the AOC's custody). A study performed by the CHP has determined that there are a number of inmates in the AOC system who currently require hospitalization for mental health conditions but who are not receiving that care as a result of the lack of beds at the Hospital. Lack of space in which to provide treatment for inmates who are acutely psychotic results in profound pain and agony for those inmates. Such inmates are a threat to themselves because they can become suicidal, and to other inmates if they are prone to aggressive behavior. Such inmates also are vulnerable to attacks from other inmates. They disrupt the order of institutions, thus creating security hazards that must be addressed by AOC staff.

128. Although a number of housing units in AOC facilities are designated as medical dormitories, they

often lack the elements necessary for true medical dormitories, such as nursing services areas, ramps for patients, hot water, examining rooms, etc. Because of a lack of infirmary beds, not all patients who require placement in an infirmary can be placed in one. Thus, for example, inmates who require observation during withdrawal from drugs or alcohol abuse may not be held in an infirmary for the necessary time.

129. Lack of coordination with the AOC hampers the completion of sick-call requests, because the AOC cannot provide sufficient numbers of custody officers to escort CHP staff to collect sick-call slips, or else cannot provide sufficient officers to accompany inmates in need of attention to the medical area. The witnesses repeatedly testified to the pervasive absence of officers needed to provide security to health care staff, to move inmates within the institutions and to transport those inmates to their outside treatment appointments or even for emergencies. This situation has reached an acute, critical point and must be remedied at once.

IV. HARM TO PLAINTIFFS

130. Since 1993, when the current Chief Health Care Coordinator was appointed, until 1995, the Correctional Health Program made remarkable progress in specific areas, to wit: it recruited more and better qualified professional staff; it greatly improved pharmacy services; it expanded the number and types of services provided to inmates achieving the level of care required by current professional standards, and it improved the quality of services provided to inmates. As a benchmark of acceptable professional performance, the Health Care Executive Committee has established 95% compliance with each provision of the Plans as their

goal. Unfortunately, deficiencies in the delivery of services to inmates persist, and in some cases these have worsened over the past two years. The progress achieved has dissolved in the face of the obstacles placed in the Program's path.

131. In virtually all key areas that can be measured statistically (including admission evaluations, ambulatory services, sick call, and extra-institutional appointments for subspecialty services), the Correctional Health Program has been unable to achieve a professionally acceptable level of performance. During the last two years, moreover, overall rates of performance have dropped at 11 out of 16 institutions (for purposes of this assessment, each correctional complex counts as one institution). At no institution did overall performance reach the 95% level. The average rate of performance at all institutions dropped from 68.9% during the 1995-1996 fiscal year to 65.2% during the 1996-1997 fiscal year. A further analysis of key services is presented below. Services that are not susceptible to statistical analysis also are currently unacceptable by professional standards of care, as explained in more detail below.

132. In addition, the Program cannot provide consistent and timely access to emergency services for inmates. AOC inmates who are prescribed specialized diets do not receive those diets. There is one optometry clinic and one physical therapy clinic for AOC inmates, but because of the lack of transportation, inmates who are not housed at the same prison where these services are provided do not have access to those services. Neither the AOC nor the CHP has an adequate system for tracking inmates receiving medical or mental health care from one institution to another. Inmates who are

transferred, therefore, are at risk for interruptions or delays in their treatment, or even incorrect treatment, which can be and has been fatal. The Correctional Health Program cannot assure that it has adequate medical supplies. Some facilities lack basic equipment necessary for the services required to be given at those facilities. For example, one of the AOC's intake centers at Sabana Hoyos has never had a functioning X-ray machine, which is necessary, among other things, to screen inmates for tuberculosis. Emergency areas in some institutions lack necessary equipment as well.

133. The deficiencies evidenced at the hearing are the result of systematic infirmities in the correctional health care scheme, which can be characterized as (a) obstructionist interference from and inefficiency within the Department of Health and other government agencies and (b) the lack of cooperation on the part of the Administration of Correction. In brief, the Correctional Health Program has been submerged by a relentless and impenetrable miasma of bureaucracy. As a result, defendants have consistently acted to prevent the CHP from functioning properly in recruiting, contracting for, and retaining essential professional staff as well as in completing the arrangements necessary to ensure access for AOC inmates to community-based emergency, subspecialty, and hospital services. There has not been timely progress toward the renovation and construction of the health care facilities that are needed by the CHP in order to attract and retain all necessary professional staff and to ensure satisfactory and efficient medical and mental health services. The AOC lacks the necessary information systems, classification systems, and administrative capacities and commitment to cooperate

effectively with the CHP in ensuring satisfactory and efficient provision and continuity of medical and mental health services.

134. It is extremely difficult to recruit professional personnel to work for the CHP. These difficulties have a number of causes. These include potential recruits' perception that working in correctional facilities is dangerous and the remote location of many correctional institutions. In addition to these issues, a number of other issues make it difficult to retain staff once hired. Among the difficulties in retaining personnel are low pay and the total lack of fringe benefits for contractual personnel, compared to that obtained in the private sector (or other government agencies), inadequate and cramped physical facilities, and lack of up-to-date equipment.

135. Because employment positions with the Department of Health and AFASS pay so little, professionals, such as physicians, physical therapists, and other specially trained health care workers cannot be hired as employees of those agencies. Instead, in order to pay a reasonable and competitive salary, the CHP must hire those professionals as independent contractors, as other health care agencies and programs do, but at times competing agencies are allowed to pay more than the CHP. These contracts must be reviewed and approved by AFASS personnel, but the process of review and approval can take months to effectuate. Because of the uncertainty inherent in waiting months for approval of a contract, health care professionals are reluctant to work for the CHP and those who do tend to leave as soon as they can obtain a position elsewhere.

136. The difficulties in recruiting and retaining staff have prevented the CHP from hiring sufficient staff to provide necessary health care services to inmates. The program never has achieved the acceptable level of staff required according to staffing needs assessments prepared by or for the program. This lack of staff has resulted in actual harm to inmates in the AOC system.

137. Bureaucratic hostility has hampered the provision of medical services in other ways as well. The CHP has had trouble obtaining clinical services because the Secretary of Health has inexplicably and unreasonably terminated contracts with outside reference laboratories.[16] AFASS, on which the CHP depends for purchasing and supplies, takes inordinate amounts of time to process bids for basic materials and often fails to pay its suppliers, who understandably cut off supplies until they are paid. Whether they are paid or not is beyond the control of CHP administrators.

138. The conditions established by the evidence have caused actual pain and suffering with no conceivable penological purpose to members of the plaintiff class. Some of the deficiencies have directly resulted in inmate deaths. Delays and interruptions in the treatment of diseases, caused by inappropriate transfers and transfers without medical records, by failure to complete health evaluations upon admission to the AOC system, or by failure to provide unitary doses or to see inmates at sick call or for ambulatory services, all result in the progression of disease or in health conditions' deteriorating to a critical state. Failure to treat inmates with acute psychiatric conditions causes catastrophic pain and suffering to those inmates. Failures to provide intake evaluations result in the spread of contagious diseases that could be

prevented if infected inmates are identified in time. Lack of infirmary beds results in inmates suffering from withdrawal symptoms being deprived of a controlled setting for their treatment, thus exacerbating the symptoms and consequences of withdrawal. Failure to provide triple therapy for inmates with HIV reduces the chances of being able to treat the disease effectively, and increases the likelihood of the onset of AIDS. Interruptions in the provision of medications for HIV or for tuberculosis through unitary doses reduces the effect of those medications, at best, and can produce drug-resistant strains of the diseases at worst. Because of lack of access to mental health services and shortages of mental health personnel, an inordinate number of suicides have occurred in AOC institutions over the past two years. These are not generalizations or a calculus of probabilities about the pain and suffering inflicted on plaintiffs, the testimony in the recent hearings indicated that specific inmates have suffered as a result of the deficiencies in the organization of the delivery of health care services, as a causal result of the defendants' policies and decisions:

> a. One inmate, who suffered from a schizoaffective disturbance was transferred to a minimum security camp. He arrived at the camp without a medical file and without his medication. The inmate never should have been transferred to the camp, due to his mental health condition, but was transferred by the AOC nonetheless. The same night that he arrived at the camp, he decompensated, entered into an acute

psychotic condition, and had to be taken to the Psychiatric Intensive Care Unit.

b. An inmate transferred to Camp Zarzal was admitted to the emergency area there with an acute illness. The medical staff at the camp did not have the necessary supplies to test the inmate for diabetes when he arrived there. Upon being admitted to the emergency area, he was hydrated with dextrose in water. The inmate subsequently died from diabetic toxidosis. The dextrostick was not available at Zarzal, and was not dispatched to the Camp until after the inmate's death because suppliers had not been paid by AFASS and had stopped deliveries.

c. An inmate with high blood pressure, congestive heart failure, and bronchial asthma was transferred from the medical dormitory at Annex 504 to the medical dormitory at Ponce. The patient refused to be housed at Ponce, and was transferred to Annex 448--a general population housing facility--at Rio Piedras. After a number of visits to the emergency room at the Rio Piedras Complex, the inmate was placed in Cell Block C2 of the State Penitentiary, which is designated as a medical dormitory. Because of the type of crime committed by the inmate, and because he was a sentenced inmate, medical staff had to negotiate an agreement from the inmate leaders at the State Penitentiary that he would not be

harmed if he was placed in the medical dormitory. Once medical staff had obtained this agreement from the leaders, the inmate was placed in the medical dormitory, but AOC personnel subsequently transferred the inmate out of the dormitory without medical authorization to Annex 352 where he could not receive the continuous observation he needed. While at Annex 352, the inmate suffered respiratory problems and was admitted to the emergency room at the State Penitentiary, where he died of cardiac arrest.

d. A CT scan of the head and neck was ordered for a patient who was admitted to the Rio Piedras Correctional complex in November 1995. The scan was ordered in November 1995 and it wasn't until April 1996 that it was conducted. The patient was released under a diversion program in June 1996, and the results of the scan still had not been received in June. In this case, where a lymphoma was suspected, no more than one week should have elapsed between the time the appointment was obtained and the CT Scan was performed. The delay in this procedure endangered the health and the life of the patient.

e. Because of the lack of a psychologist at the Ponce intake center, an inmate suffering from drug withdrawal at that center committed suicide on May 27, 1997. The inmate had been admitted for a minor crime,

but did not receive the standard mental evaluation upon admission because no psychologist was on duty, even though there was supposed to be one. Thus, no one was available to determine whether the inmate was a suicide risk. The inmate also required admission to an infirmary, because of his withdrawal symptoms; had he been admitted to the infirmary, he would have been under 24-hour close supervision. There were no beds available at the time of his admission, however, and he thus lacked not only the mental health evaluation, but also the close supervision he should have received.

f. CHP staff identified a patient at Camp Punta Lima whose PPD test indicated exposure to tuberculosis; because of the lack of isolation rooms in the AOC system, this inmate could not be properly isolated pending determination of his medical status. Because the Rio Piedras complex' isolation rooms were not functioning, the inmate was referred to the Humacao Regional Hospital. The hospital, however, returned the patient to Punta Lima without having any tests performed. Because of the persistence of the medical director at Punta Lima, the patient eventually was taken to be evaluated by an internist at the Rio Piedras complex. A valisoscopy of the inmate's sputum was performed, and it was determined that the inmate had active tuberculosis. The CHP's epidemiologist visited Punta Lima, and

identified 11 inmates who had had contact with the infected inmate, and who had converted to a positive PPD from exposure to the disease.

The Strategic Evaluation

139. In 1996, the Health Care Executive Committee conducted a strategic evaluation of the CHP. The evaluation involved all of the members of the HCEC and the office of the court monitor. Participants visited all facilities, interviewed line and leadership staff, and reviewed documents, logs, and records.

140. The strategic evaluation used 1993 as a baseline for comparison of the status of correctional health services, and covered the 1994-1995 and 1995-1996 fiscal years. The HCEC chose 1993 as the baseline because that is when the Chief Health Care Coordinator began working, and also because there really was not a lot of data available for the years prior to 1993.

141. The strategic evaluation identified the strengths and weaknesses of the program. The strengths identified by the evaluation included a significant increase in the number of professionals the program had been able to recruit, that the beginnings of a fragile organized health care system were in place, that substantial progress had been made in implementing an infectious disease program, that the central office staff were working at a high level of competency and as an integrated team, and that data collection, although being done manually, was being performed, that records were legible and well-kept, that services that in 1993 existed only minimally had been developed, such as dental services, mental health services, health education and infectious disease

control, that there was a reasonable preparedness for emergencies and managing medical emergencies, and that the program had established licensing procedures and obtained licenses for its pharmacies.

142. The weaknesses identified during the strategic evaluation included inadequate physical facilities, lack of an information tracking system, lack of integration with AOC personnel, and lack of administrative flexibility. The principal threat identified during the strategic evaluation was the unavailability of resources to develop the Program.

143. At the time of the strategic evaluation in 1996, the HCEC determined that the CHP's strengths outweighed its weaknesses and that the program also had improved its ability to protect the health of the inmates. Unfortunately, the CHP has been losing ground since the strategic evaluation was conducted in 1996. What progress has been maintained is extremely fragile and could regress further if changes of a substantial nature do not take place soon.

144. Currently, the CHP is not in substantial compliance with the Plans. The program has suffered decreases in staffing levels since 1995. There has been no substantial progress in the coordination of medical services between the AOC and the CHP. Not all specialties--medical, mental, dental, etc.--work together because the CHP does not have all the necessary components at all the appropriate institutions. The CHP is not in compliance with the requirement of an integrated appointment system. Various services are available, but inmates do not have access to the services. The CHP cannot complete intake assessments due to insufficient staff and because AOC personnel

transfer inmates prematurely. Overall compliance with the objectives for sick call, ambulatory services, admissions evaluations, and extra-institutional appointments fell from 68.9 percent in the 1995-1996 fiscal year to 65.2 percent in the 1996-1997 fiscal year.

145. The CHP has been losing ground over the past two years in its attempts to achieve compliance with the Medical and Mental Health Care Plans. Not only has compliance not been achieved, the situation is deteriorating and is characterized by what the CHCC described as "back sliding from a non compliance position." Even defendants' own expert concedes that inmates in the Puerto Rico prison system are provided with inadequate health care.

Intake Evaluations

146. The Correctional Health Program has never been able to complete 95% of intake evaluations.[17] The rate of completed intake evaluations, in fact, has fallen from 76.2% during the 1995-96 fiscal year to 68.4% during the 1996-1997 fiscal year. Intake evaluations are the cornerstone of correctional health services, because identifying inmates' health needs upon entry into the prison system allows health care staff to develop treatment plans for individuals with health needs and to control the spread of infectious diseases within the system. Thus, there are numerous inmates in the AOC system who have not received a complete medical or mental health evaluation. This increases the risk of the spread of disease, and threatens the health of inmates whose conditions require special care, but whose needs have not been identified. In addition to integration of health care services, an inmate tracking system is

necessary so that a patient who requires follow-up or further care does not get lost in the process.

147. The AOC frequently transfers inmates out of intake facilities before these evaluations are completed. Thus, the opportunity to treat inmates with infectious diseases before they enter the general population is lost. In addition, inmates who may require a certain level of treatment may not receive that treatment at all, or else the treatment may be delayed. Because of the failure of AOC staff to send inmates' medical files along with the inmates upon transfer. All too frequently the only way that CHP staff become aware of the presence of an inmate in an institution is if the inmate puts in a sick-call slip or is brought to the emergency area.

148. The evaluation is important for the diagnosis of any acute or chronic medical or mental problem, which in turn can forestall potential exposure of others to communicable diseases that can be treated. In addition, the initial evaluation allows staff to determine the correct housing assignment for each inmate. A mental health assessment allows staff to detect inmates with mental conditions and to place them in an environment in which they would be able to function. To identify those people most at risk, the intake period is crucial, because inmates with mental conditions may be vulnerable and unable to protect themselves from other inmates. Inmates with particular health needs must be housed in an institution that has facilities and personnel available for treating those needs.

149. The initial intake screening includes oral inquiry into current illnesses, medications, health problems and conditions and suicidal ideation; taking of

vital signs including weight; observation for clinical abnormalities (e.g., behavior, appearance, injuries, deformities, and psychotic behavior); implantation of a skin test for tuberculosis (PPD); and documentation of the patient's disposition (referral to physician, to general population, or psychiatric team). Medical Care Plan at III.B.11.

150. The full health assessment includes review of intake screening results, expansion of the medical history, laboratory and diagnostic tests to detect communicable diseases, physical examination, and initiation of required treatment and examination. There are additional requirements addressing the special medical needs of women. Medical Care Plan at III.B.13.

151. Dr. Torres gave a practical description of how the admissions process works. When the inmate arrives at the admissions department, a doctor opens up a medical file and conducts a physical examination. He also conducts a pre-counseling session in which he advises the inmate to authorize an HIV test. On the order sheet, the doctor writes down the tests that he wants conducted. For example, he may want staff to conduct a CBC test, a urinalysis, a VDRL test, chest x-rays, and a tuberculin test. Doctors also conduct dental, mental health and health education screening. Finally, the inmate is given three appointments: one appointment for the reading of the tuberculin test, one appointment to discuss the results of the laboratory tests (two days after they are conducted), including the HIV test if applicable, and postcounseling. And one appointment for the following year for a new physical examination and pertinent lab tests.

152. Noncompliance with these admissions requirements is widespread. Compliance at the five regional intake centers with the requirement that the admissions process be completed within days fell from 76.1% in 1995-96 to 68.3% in 1996-97. At the State Penitentiary at Rio Piedras, the rate was 59.6%; at Sabana Hoyos, it was 42.3%.

153. In some cases, failure to complete the admissions process timely simply means that it is completed later. Often, however, it is not completed at all, because the Administration of Correction transfers many patients away from the regional intake centers before the assessment is completed--and in many cases, before the 7 days provided by the Medical Care Plan for the assessment. Medical Care Plan at § III.B.13. Such transfers violate the Medical Care Plan, which requires (at § III.B.14): "No individual shall be transferred from a regional intake facility until his intake health screening, initial history and full health assessment are completed unless the transfer is to another regional intake center."

154. AOC does not give notice before removing inmates from the intake centers, despite a 1992 court order requiring such notice. These transfers without records occur because AOC does not consult with Correctional Health personnel on all transfers, and when it does consult, it often does not give notice in time to produce the medical record. This practice violates a 1992 order that provides: "Defendants should develop immediately an agreement between the AOC and DOH to ensure that correctional staff notify medical staff of an inmate's impending transfer, so that medical staff can prepare the inmate's medical record for transfer." Order, December 28, 1992, at § XV.2

(Dkt. 4166). Official policy states that CHP is to have 72 hours to review inmates' files and recommend for or against transfer, but the policy is not complied with. The CHCC has asked to be given 48 working hours for this purpose, but her request has not been honored.

155. Prisoners who are transferred to another intake center, but not to an intake building--or even to another building in the same complex--may still not receive their admission assessment and may not come to medical staff's attention until and unless they request sick call or a clinic appointment or arrive at the emergency room. Prisoners do not always do this, especially persons who are mentally ill. These prisoners are at particularly great risk of being lost in the system. Persons admitted Friday through Sunday, when certain laboratory services are not available, are particularly likely to be transferred before their assessments are completed.

156. At Ponce, about 66% of newly admitted inmates are removed before 7 days. Some 12% are bailed out, but most are transferred to other complexes or elsewhere in the Ponce complex. Only 33% are completed. If they are transferred within Ponce, medical staff try to find out where they are and complete the admissions process. In FY 1996-97 at Ponce, 3,604 inmates who were admitted were not evaluated. Of these 2,044 (56.7%) were transferred before their assessment was completed, and 1,307 (36.3%) were released from prison. The remainder were hospitalized or transferred to other medical facilities.

157. A smaller fraction of Rio Piedras prisoners are transferred before the seven days have elapsed. However, other causes have prevented compliance with

the admissions requirement at Rio Piedras. Compliance reached and exceeded 90% in 1995-96 but then dropped precipitously in 1996-97. The Medical Director cited insufficient medical staffing, high turnover among staff and the attendant disruption, the lack of custodial officers and transportation, shortages of x-ray films, the unavailability of laboratory services on weekends, and for a long time the availability of only one x-ray technician. The shortage of holding cells at the prison hospital, which are usually filled with patients for clinics, delays bringing admissions patients for required x-rays. Sabana Hoyos received a new x-ray machine two years ago for its intake center. However, the area where it was to be installed was never prepared. The machine was then brought to Rio Piedras. If installed in the admissions area, it would expedite admissions processing by obviating the need to take prisoners to the hospital for x-rays. But the AOC, which controls the physical plant, has failed to complete the preparation of the Rio Piedras site as well. In general, Dr. Guzman described a situation in which the personal efforts of staff are defeated by the lack of a system.

158. At Sabana Hoyos, staff shortages have been so bad for the year before the hearing (and particularly the last three months) that the prison cannot arrange the necessary physician coverage to conduct admissions assessments.

159. At Bayamon, as of the hearing, admissions assessments were covered only because the doctors work enormous amounts of overtime, 70 to 80 hours a week in Dr. Torres' case and 90 hours or more in that of the director of admissions. The AOC does not provide the medical staff with lists of new admissions, and in

some cases inmates are brought to the admissions area only after the seven days have already passed. Young adult inmates (ages 18-20) are transferred from the admissions area to other locations in the complex after no more than 24 hours.

160. At Ponce, problems in recruiting staff have obstructed completion of the admission process. The lack of sufficient escort officer to take prisoners to x-rays delays the process, and AOC uses admissions holding cells as overflow when the prison is overcrowded, which interferes with the medical staff's ability to work.

161. Failure to complete the admissions process poses significant risks to the health of plaintiff class members.[18] Persons with medical conditions requiring treatment may not be diagnosed and treated. Persons receiving medication for chronic conditions may have their medication interrupted, which in some cases may lead to the development of resistance to the medication. Mentally ill persons, if they are not evaluated on admission, may have decompensated by the time they come to the attention of mental health staff. The risk of suicide among prisoners is particularly great during the first 48 hours of incarceration. The presence of untreated mentally ill persons in the population presents risks both to those persons and to others in the prison population, since their disorders may render them either fragile and vulnerable or aggressive, and since their behavior may evoke hostility from other prisoners. Persons with communicable diseases may not be identified and treated, putting other prisoners as well as themselves at risk. The crowded prison environment presents a high risk of transmission of respiratory, skin and bloodborne infections and the

correctional population is already a high-risk population for these diseases. Many prisoners requiring drug detoxification are transferred before this process is completed.

Sick Call

162. The Correctional Health Program never has been able to achieve 95% overall performance in sick-call appointments. The percentage of sick-call requests by inmates that resulted in patients being seen by medical staff in fiscal year 1996-97 exceeded 95% at four institutions (for purposes of statistic, each correctional complex counts as one institution); of the remaining 12 institutions, the rate dropped from the prior fiscal year.

163. The Medical Care Plan requires defendants to "establish a standardized system for the daily handling of non-emergency request for medical or dental care by inmates," PIII.C.16, and more generally "to create a system that guarantees accessibility to health care services for all inmates." PII.7, objective (3).

164. Sick call is the gateway through which patients gain access to medical services. To attend sick call, a prisoner fills out a paper request and gives it to a nurse.

165. The percentage of sick call requests honored decreased from 81.3% in 1995-96 to 77.5% in 1996-97, with individual prisons having 1996-97 compliance rates as low as 64.3% (Bayamon), 74.4% (Sabana Hoyos), 69.1% (Ponce), 76.4% (Punta Lima), 78% (Mayaguez), and 68.7% (Fort Allen).

166. The reasons for noncompliance with the sick call requirement include both lack of correctional officers to escort prisoners, T44 (Dr. Torres, referring to 308 at Bayamon), and lack of physicians to conduct

sick call. T165-66 (Dr. Ramos) (citing a shortfall of three or four M.D.'s at Ponce, and one recent month when the prison had no doctors to cover sick call; at present he has only one physician for sick call.)

167. The percentage of compliance with sick call requirements decreased from 81.3 percent in the 1995-1996 fiscal year to 77.5 percent in the 1996-1997 fiscal year.

168. At Bayamon 308, sick call is not carried out on a regular basis because of the lack of officers.

169. Throughout the Rio Piedras complex there is a medical area for sick call in each institution. The sick call area at the State Penitentiary is on the second floor, where there are also located the emergency room, the internal medicine clinics, the surgery clinics, X-rays, and the medical records department. Inmates being brought to the area for sick call are strip searched, which discourages inmates from attending sick call.

Medical Records: Failure to Transfer Records with Patients:

Multiplicity of Records

170. The Medical Care Plan requires: "The complete medical record ... shall accompany all inmates being transferred from one institution to another for housing." V.D.64.g.

171. The AOC consistently transfers inmates without their medical records or without first consulting medical staff concerning transfers. During the 1996-1997 fiscal year, the Administration of Correction transferred approximately 6,394 inmates without transferring their medical records at the same

time. When an inmate is transferred without the inmate's medical record, CHP personnel at the receiving institution may not be aware that the inmate has been placed in the institution, and, if they are aware of the inmate's presence, do not know the inmate's medical history or current medical condition. Thus, transfers without medical records can result in interruptions or delay in treatment. If health care staff are not consulted prior to an inmate's being transferred, this can result in inmates with chronic medical or mental health conditions being transferred to an institution that is not set up to offer the services needed by the inmate.

172. In 1966-97, in an inmate population of 11,610 there were 6394 transfers of inmates without medical records.

173. For example, at Ponce in FY 1996-97, 18.54% of inmates transferred into the facility arrived without medical records (1,098) inmates; 7.87% who were transferred out left without records (954 inmates). When an inmate is transferred without a medical record, a temporary record is created. In 1996-97, there were 9400 temporary medical records extant in the system.

174. These transfers without records occur because AOC does not consult with Correctional Health personnel on all transfers, and when it does consult, it often does not give notice in time to produce the medical record. This practice violates a 1992 order that provides: "Defendants should develop immediately an agreement between the AOC and DOH to ensure that correctional staff notify medical staff of an inmate's impending transfer, so that medical staff can prepare

the inmate's medical record for transfer." Order, December 28, 1992, at § XV.2 (Dkt. 4166). Official policy states that CHP is to have 72 hours to review inmates' files and recommend for or against transfer, but the policy is not complied with. The CHCC has asked to be given 48 working hours for this purpose, but her request has not been honored.

175. Often medical personnel at the transferring prison learn of transfers only when a prisoner whose records are still at the prison fails to appear for an appointment or is not present to receive his unit dose medication. At the receiving prison, medical personnel may learn of the missing records only when the inmate requests services or appears with a medical emergency and no chart can be found.

176. Failure to transfer medical records when the prisoner is transferred is not consistent with the goal of an integrated medical care system.

177. This absence of medical records presents risks to patients that may be life-threatening in some cases, given the wide range of chronic conditions among the population. Patients receiving medications may not receive them timely, which in some cases may lead to relapses and even to development of resistance or to a "rebound" effect of the disease. They may also miss specialty appointments.

178. CHP personnel make informal efforts to locate medical records by communication with CHP offices in the prison the patient was transferred from and notifying the medical records administrator at the central office. Even when this process works, it may take two weeks, and it does not correct all transfers without medical records. It is not a system.

179. One of the strengths of the CHP identified by the HCEC during the strategic evaluation in 1996 was that CHP records were legible and well-kept. Unfortunately, many inmates are transferred between institutions without their medical records. During fiscal year 1996-1997, 6,394 inmates were transferred from one AOC facility to another without their medical records. From July 1996 to July 1997, 18.5% of the transfers received at the Ponce Complex arrived without medical records, and 7% of the inmates transferred from the Ponce Complex to other institutions were sent without medical records. Transferring inmates without their medical records violates the principles of an integrated health system.

180. The failure to accompany inmates with their medical records results from not providing CHP sufficient notice of a pending transfer. This in turn results from the emphasis placed on overcrowding in the Morales Feliciano litigation. Inmates are moved constantly to avoid overcrowding, regardless of their condition or handicap.

181. One of the problems in transferring inmates without their medical records is that physicians at the receiving institution may not be able to easily confirm whether an inmate has been prescribed medication. If an inmate receiving medication is transferred without his or her medical record, the continuity of the delivery of the medication can be interrupted. For example, if inmates on triple therapy for HIV infection are transferred without records, and without an effective inmate tracking system, the CHP cannot follow patients from one institution to another; those patients will miss dosages and the efficacy of the medication will decrease. Disrupting the continuity of medications can

ultimately lead to resistance to medication. Some medications, if stopped abruptly, cause a "rebound" phenomenon. A transfer without medical records also can result in a missed appointment for treatment or diagnostic intervention.

182. The absence of an inmate's medical record also has critical consequences because patients with emergent medical problems arrive at the emergency room with chronic diseases and mental conditions, yet emergency room personnel do not know of these conditions. In an emergency situation, a patient is exposed to a risk of harm to his health or even his life.

183. Transferring inmates without informing CHP staff means that inmates get "lost" in the system, because neither the CHP nor the AOC have an effective inmate tracking system. CHP staff can sometimes track inmates through the system by using pharmacy records. This informal system was developed internally by CHP staff. This informal system cannot correct all of the problems created by the failure to transfer medical records.

184. Some inmates have more than one medical record. An inmate may have more than one medical record if the inmate is admitted to one institution and then released, and later the same inmate is admitted through a different institution. Unless the inmate informs medical staff of the existence of the prior record, CHP staff may not discover the prior record. The existence of multiple medical records is a potential source of confusion for CHP personnel.

185. When inmates are transferred without their medical records, staff at the receiving institution may not even be aware of the inmates' presence. CHP staff

must periodically check AOC inmate movement records to determine if inmates have been received at an institution. Other times, CHP staff discover the presence of an inmate when the inmate shows up for sick call or seeks medical care through the emergency room, or else requests a clinic appointment. Once CHP staff have determined that an inmate is present without a medical file, they must attempt to locate the inmate's institution of origin through the AOC's records, and then request the original medical file. It can take two weeks to locate and obtain an inmate's medical file. At the sending institution, CHP personnel discover an inmate's absence only after an inmate misses an appointment for medical services or when medical personnel attempt to deliver unitary dosages and find that the patient no longer resides at the institution. While staff at the receiving institution attempt to locate and retrieve the original record, they must reconstruct the inmate's medical history and create a temporary file. This process creates an unconscionable number of temporary records.

186. Patients that are transferred from one institution to another without their medical file are supposed to pass through the medical area in admissions at the receiving institution. CHP staff then open a provisional file, which is used until the medical file arrives. This process creates a duplication of files and taxes the resources of nursing and medical staff. In July 1997, the AOC system had 9,400 temporary medical records.

Transfers Without Review by CHP

187. Court orders require that the AOC provide CHP staff with notice that an inmate will be

transferred, so that the inmate can be transferred to an institution with appropriate medical facilities. The AOC does not consistently comply with these orders. CHP staff require at least 48 hours' notice that an inmate is to be transferred to review the inmate's record, assuming that they have access to the record, and make a recommendation concerning the institution to which the inmate can be transferred. The CHP's internal protocols establish an optimal period of 72 hours' notice to review the medical file and, depending on an inmate's medical and mental conditions, to approve or disapprove a transfer. This protocol is not consistently followed.

188. Transferring inmates without first allowing medical personnel to review the inmates' files can endanger the health of the inmate. For example, a number of inmates have been transferred to Camp Guavate with chronic medical conditions that cannot be adequately treated at that institution.

189. The AOC sometimes independently of the efforts of the medical staff, places chronically ill patients including patients with HIV, in facilities inappropriate to receive the medical treatment they require. They are transferred to a variety of facilities, camps, or smaller prison facilities, and the input of the medical staff is not utilized. If the transfer of inmates is done without medical input, the disease burden at a given facility will exceed the capability of the resources.

190. Patients with medical conditions requiring close supervision are being transferred to institutions, such as Guavate Camp, which lack a medical dormitory and the appropriate staff or resources to cater to their

medical needs. These patients are transferred without their medical files.

191. Camp Guavate does not have mental health staff qualified to treat seriously mentally ill patients, thus those inmates should not be assigned to said penal institution since adequate medical treatment cannot be afforded. Patients suffering major depression, for example, should not be confined at Camp Guavate. Notwithstanding the above, a mentally ill inmate with a diagnosis of schizoaffective disorder was transferred to Camp Guavate without his medical file. His condition deteriorated the same day he was transferred and he had to be returned that same night to the Psychiatric Intensive Care Unit in Rio Piedras for evaluation and treatment. Another inmate suffering from major depression was sent to Camp Guavate, without his medical file, posing a risk to his life, since failure to provide adequate mental treatment could have led to suicidal ideation.

192. A patient with a cardiac condition and a major depression history was transferred to Camp Guavate, which lacks the human and medical resources to treat and monitor his medical condition. This inmate takes Visteril and Cumadin-an anticoagulant-and should have blood tests performed regularly to avoid suffering an hemorrhage and a hypobulemic shock which could threaten his life. Because of his physical condition, the inmate should be assigned to a medical dormitory where he could be under close medical supervision. That supervision could not be provided at Camp Guavate.

193. Another inmate suffering thrombocytopenia, a blood disorder which could lead to hemorrhages, was

transferred to Camp Guavate in 1997. He should have been assigned to a medical dormitory. An inmate suffering from uncontrolled juvenile diabetes also was transferred to Camp Guavate. He too should have been placed in a medical dormitory, where his condition could be closely monitored.

194. The CHP is not in substantial compliance with the requirement of performing an admissions assessment; in fact, the CHP never has achieved the 95% completion goal. The percentage of completion of intake health evaluations dropped from 76.1 percent in the 1995-1996 fiscal year to 68.3 percent in the 196-1997 fiscal year. The primary reason is that inmates are transferred by the AOC before the admission process can be completed. This is in spite of initial signs of improvement shown in 1994 and 1995. The rate of non-compliance with the admission assessment requirements also results from difficulties in hiring necessary personnel and from inmates being removed from intake institutions prior to the completion of their health assessment. In fiscal year 1996-1997, 5,967 inmates were transferred out of intake centers before seven days following their admission. In other instances, some institutions do not have the equipment necessary in order to complete intake evaluations.

195. Between early transfers and early releases, approximately 11,400 out of approximately 28,000 admissions do not complete the admissions evaluation, even though the CHP has begun to invest time and money in performing evaluations of those prisoners. The failure to complete intake assessments has a negative effect on the CHP's attempts to control infectious disease. Some inmates could have chronic medical diseases or present symptoms of withdrawal

from drugs or alcohol; they can represent a danger to the population and to themselves if not tracked and treated properly.

196. In the Ponce Complex, during the last three years, only 33% of inmates admitted to the institution receive a complete intake evaluation. The remaining 66% are either transferred by the AOC or released on bail before the intake evaluation can be completed. Similarly low percentages prevail at the Bayamon Complex, where the current rate of completion is approximately 50%. There were three months during 1996 at which the completion rate was 0% because of the lack of medical staff to perform intake examinations. Most admissions occur at night. If a physician is not available to cover a night shift, the admission process cannot be completed.

197. The most frequent way in which CHP staff discover an inmate who has been transferred without a complete intake evaluation is when the inmate shows up for sick call or seeks medical care through the emergency room, or requests a clinic appointment. But not all inmates request sick call or other medical care shortly after their admission. Mentally ill patients report to medical areas less frequently than do other inmates. Thus, mentally ill patients are at a particular risk of being lost in the system if they are not given an initial intake evaluation. If an inmate requires mental health treatment but does not receive it, a number of problems can result: the inmate can be very vulnerable to physical abuse by other inmates; the inmate can cause problems for the general population and staff, because the inmate can become disruptive; the inmate diverts attention by prison staff, so that they cannot deal with other problems; failure to treat also causes a

great deal of pain for the mentally ill inmate; the inmate can also can be at risk of harming him- or herself.

198. The completion of intake evaluations at Rio Piedras in July 1995 was only 30.6%; this was increased to 90% in 1996. The rate fell dramatically, however, after May 1996 to approximately 5%. This decrease results in part from a shortage of physicians. This decrease also results from the lack of custodial officers and the lack of transportation to take patients to the hospital across the courtyard to have X-rays taken. Moreover, there are no laboratory services available during the weekend. A backlog of inmates awaiting lab test results, and when lab services are available again on Monday mornings, there are not enough officers to bring the inmates to the medical area. The failures in the admission process at Rio Piedras affect the health of persons admitted to the complex. The delay in the diagnosis of infectious conditions, chronic mental conditions, and withdrawal symptoms causes the interruption of treatment until admissions staff are able to identify the medical conditions of each patient.

199. The Bayamon Correctional Complex, also lacks physicians to conduct all the admissions evaluations. CHP personnel attempt to deal with this shortage of physicians by assigning doctors to night watch for several days each week. Some physicians, therefore, work 80-hour weeks. As a result of these conditions, the morale of the physicians is being affected, to a point that some are threatening to resign. The AOC sometimes transfers inmates undergoing withdrawal from the admission area to other areas in Bayamon or to other institutions. Frequently, inmates that arrive from the street are placed in the general population before a medical and mental history examination is

performed and chest X-rays and labs are taken. This has medical consequences in the general population because a patient could be carrying a communicable disease.

200. CHP staff at the Sabana Hoyos Correctional Institution report that the facility has the lowest compliance of correctional facilities in Puerto Rico in completing intake evaluations. The CHP is practically in total non-compliance with the Plans at the Sabana Hoyos Correctional Institution. The CHCC, over the past four years, has been told a number of times that admissions in the western region of the island will be changed to Guerrero, only to be told on a number of occasions that this plan has changed. This has hampered the development of admission health services at Sabana Hoyos because, if admissions are to be moved to another facility, it does not make sense to devote resources to developing a full complement of admissions services at Sabana Hoyos. Nevertheless, the change to another facility has never been implemented by the AOC.

201. Approximately two years ago, the CHP successfully tested the entire prison population for tuberculosis. At the end of these tests, CHP staff knew who in the AOC system was potentially at risk of developing active TB. This is no longer true because failure to complete intake assessments has made it impossible to determine accurately the number of PPD positive inmates in the system.

Failure to Select Medically Safe Housing

202. Generally, there is no system by which the defendants take into account prisoners' medical condition in making housing placements. Although CHP

reviews medical records and makes recommendations concerning proposed transfers to private prisons, there is no such procedure for AOC facilities. Official policy states that CHP is to have 72 hours to review inmates' files and recommend for or against transfer, but this policy is not complied with, and the CHCC's requests for 48 hours for this purpose have not been heeded.

203. In practice, the regional intake centers are the locations that best comply with requirements for chronic patients. The defendants do not concentrate persons with chronic disorders in the regional intake centers. Rather, they disperse many of them to facilities such as camps which do not provide adequate care for such patients and are remote from emergency services. This failure to place chronic patients in facilities with an appropriate level of care is inconsistent with the goal of an integrated system.

Transportation of Inmates to Emergency Facilities

204. Many inmates who are brought to medical facilities requiring emergency services must be taken to outside emergency facilities, and for the last six years there have been delays in transportation either from one prison in a complex to another to reach the emergency facilities, or from the prison to an outside hospital. There are problems related to the transfer of inmate patients between services to the various facilities complexes and the regional secondary facility because of either the unavailability of a working emergency vehicle and/or the lack of correctional officers. Delays of up to four hours were reported. The standard of care to prevent morbidity is a fifteen to twenty minute wait for an ambulance. Increased

morbidity, deterioration of conditions, increased symptoms such as pain and suffering are all caused by delays in transporting an inmate to an emergency room.

205. Records show that within the last twelve months, 15 deaths occurred and the record also indicates that inmates are brought to the medical unit by other inmates, which reflects a system completely dependent upon inmates, which can only result in unnecessary deaths.

206. On Saturday, August 2, 1997, during a visit of representatives of the AOC and Dr. John H. Clark, defendants' correctional health expert, to the Bayamon Correctional Complex, an inmate suffered a head injury. This patient was taken to the emergency ward, but due to the neurological changes he was presenting he needed to be transferred to the Medical Center emergency room in Rio Piedras to have a CT scan. At that moment there was an ambulance at the emergency area, but there was no officer who could start or drive the ambulance. This delay in transportation to emergency rooms is a common experience if emergencies occur after 4:0 p.m. at the complex. The patient arrived at the Bayamon 1072 emergency ward around 2:00 in the afternoon, and it wasn't until 6:00 p.m. that he was finally transferred to the Medical Center. This patient should not have been more than 15 or 20 minutes in the emergency room waiting to be taken to the hospital. This unacceptable delay in transferring the patient to the emergency room exposed him to a risk of harm or even death.

207. An inmate at Bayamon who suffered left chest trauma presenting a diminished lung sound, pallor and tachycardia was transferred to an outside emergency

room almost two hours after the referral to the hospital. This type of delay is not medically acceptable. The delay posed a serious risk to this patient's health, who had a rupture to the spleen which had to be removed. Another inmate at Bayamon with a history of arterial hypertension, congestive heart failure, bronchial asthma and insulin dependence, diabetes mellitus and a history of coagulopathy, who arrived at the prison's emergency room with rectal bleeding, was transferred to the outside emergency room almost 5 hours after being referred to the hospital. That delay was medically unacceptable. He should have been transferred within 15 to 20 minutes. Also medically unacceptable was a 24 hour delay in transferring an inmate who suffered a fracture of the left hand with a degree of deformity. There was also a 24 hour delay in the case of an inmate suffering a fractured finger. Like the other inmate, he could have developed a deformity and subsequent medical treatment would have been more profound. Another inmate suffering persistent seizures was transferred to a hospital six hours after being referred. This is medically unacceptable and posed a risk to his health for he could have suffered cerebral damage.

208. Emergency transfers between modules inside the institution, and between institutions at the same complex, are also characterized by unacceptable delays. The transfer of an inmate suffering a left and right eye trauma took approximately two hours. The delay could have led to problems with his eyesight. Another example is that of an inmate suffering of trauma to his head and left costal area whose transfer took over two hours. Similarly, there is undisputed evidence on the record of two other inmates suffering head trauma and multiple trauma whose transfer from one module to

another inside the institution took approximately two hours. The delay posed a threat to their health.

Off-Site Appointments and Subspecialty Clinics

209. Although completion of extra-institutional appointments rose from 60.8% in the 1995-1996 fiscal year to 61.8% in the 1996-1997 fiscal year, that rate of performance is still unacceptable. In addition, 69% of individual correctional institutions suffered a decrease in performance with respect to extra-institutional appointments in the 1996-1997 fiscal year.

210. The Correctional Health Program never has been able to achieve 95% completion in the area of off-site appointments. These appointments are necessary to provide specialized health procedures--such as computerized tomography scans and major surgery--that cannot be provided at the institutional level within AOC facilities. During the 1995-1996 fiscal year, 41.5% of off-site appointments were missed. During the 1996-1997 fiscal year, 38.2% of appointments were missed. The rate of completion of off-site appointments dropped at 11 of 16 institutions from the 1995-96 to the 1996-97 fiscal years (for purposes of this statistic, a correctional complex counts as one institution): the rate did not exceed 81% at any institution, and at most institutions, was below 75%.

211. The program does have an internal process for obtaining and scheduling extra institutional medical appointments, which is somewhat effective. The problem in getting inmates to their medical appointments inside or outside of prison is the result of inefficient custodial escorts. In addition, first priority is given to transporting inmates to court, and the shortage of vehicles results in inmates' not being taken

to outside medical appointments. Even if a vehicle is available, there may not be an escort or, if an escort is available, there may not be a vehicle.

212. Under the CHP's internal procedures, a contact at the Rio Piedras Medical Center obtains the appointments and faxes them to the CHP's central office, from which point notice of the appointments is communicated to the prisons. Correctional Health staff then notify AOC personnel of the appointment two or three days beforehand. The AOC has never complained to the Chief Health Care Coordinator that it does not receive sufficient notice of inmates' off-site medical appointments.

213. Even when Defendants took direct steps to resolve the problems in taking inmates to offsite appointments, the AOC has not been able to carry through with those efforts. For example, pursuant to a security stipulation, the Chief Health Care Coordinator designated the Rio Piedras State Penitentiary as a priority institution, met with officers at that institution, and designed a plan for providing medical escorts. The escorts were assigned for two or three weeks, but suddenly the officers were removed from medical escort duty.

214. Delays in obtaining appointments in off-site subspecialty clinics threatens the continuity of a patient's medical care. At the Rio Piedras complex, for example, it can take seven months to get an orthopedic clinic appointment, and if the patient misses the appointment for lack of a vehicle or custodial officer, it can take another six months to obtain another appointment. Extra institutional appointments are delayed and canceled and in some cases inmates may

wait months to schedule an appointment. If the appointment gets canceled, it can take a year for the visit to finally take place. These delays are unacceptable and pose a risk to the health and safety of inmates, prolonging unnecessary pain and discomfort. The delays can also cause conditions to deteriorate to a point where they are no longer treatable.

215. At the Ponce Complex, inmates who require subspecialty medical attention are referred to the Ponce Regional Hospital. If that hospital does not offer the necessary specialty, a referral is made to the Puerto Rico Medical Center. The Ponce Complex, however, has serious problems with extra institutional appointments. The Ponce Correctional Complex is not providing inmates transportation to off-site appointments. This problem affects the follow-up of the patient in the outside institution that usually has arranged for a specialist or for a special study. Also, this problem affects compliance with the Plans, because Correctional Health personnel cannot complete the evaluation or treatment of the patient.

216. There is a significant problem with transporting inmates to off-site appointments and in getting timely off-site appointments at the Rio Piedras Complex. The Bayamon Complex also suffers from a lack of dependable vehicles and a lack of escort and transportation staff to take inmates to off-site medical facilities.

217. In addition to depriving inmates of health care, the inability of the AOC to get inmates to medical appointments results in wasted resources. The Plans provide that if the delay in getting inmates to outside clinics is more than four weeks following a referral,

efforts should be made to provide subspecialty clinics on-site at the prisons. The Chief Health Care Coordinator has attempted to reduce reliance on extra institutional appointments by bringing subspecialists into some of the prisons. CHP staff found a number of specialists willing to offer clinics in some prisons, but the program could not contract with those specialists for two reasons: first, they wanted to be paid for each clinic they attended, but the program did not have the administrative mechanisms to hire on those terms; second, there is insufficient space at the institutions to hold the clinics.

Ambulatory Services

218. The Correctional Health Program never has been able to achieve 95% delivery of ambulatory medical services. Ambulatory medical services are general outpatient medical services. The rate of provision of ambulatory medical services fell from 59.6% during the 1995-1996 fiscal year to 57% during the 1996-1997 fiscal year. The highest rates for ambulatory medical services at individual institutions were 94.9% at Stop 8 (an institution with a capacity of 59 inmates) and 99.7 percent at Camp La Pica (an institution with a capacity of 160 inmates). At the remaining AOC institutions (with a total capacity in excess of 12,000 to 14,000 inmates), no institution achieved a rate higher than 74%.

219. Performance in completing ambulatory services dropped from 59.7% in the 1995-1996 fiscal year to 57% in the 1996-1997 fiscal year. Overall compliance with objectives for sick call, ambulatory services, admissions evaluations, and extra institutional appointments fell from 68.9% in the 1995-1996 fiscal year to 65.2% in the

196-1997 fiscal year. This reduction was echoed at both the Rio Piedras State Penitentiary and the Mayaguez Western Detention Center. In addition, at the Ponce complex, mental health ambulatory services and mental health patients are not fully served in terms of their monthly evaluations and their regular medications.

220. The problems experienced by the CHP with respect to ambulatory and extra-institutional medical appointments have a greater effect on persons with chronic conditions.

HIV+ and AIDS (Triple Therapy); Hepatitis C; Tuberculosis

221. The Program does not provide the current modality of standard medical treatment indicated for HIV and AIDS patients. The treatment termed "triple therapy" is the standard of treatment for many HIV patients. Failure to provide the treatment to those for whom it is indicated increases the likelihood of morbidity and mortality.[19] Approximately 60-70% of HIV or AIDS patients in the AOC system would benefit from triple therapy if it were properly administered. In order to start and properly administer triple therapy for HIV or AIDS patients, three elements are necessary: higher rate of compliance with medication administration, additional staff, and an adequate budget to purchase the drugs and perform testing. Part of the reason for the failure to provide triple therapy is the budgetary constraints suffered by the CHP. Initial and periodic viral load tests, in addition to other types of tests, are necessary, and these all carry their own economic costs.

222. As an initial evaluation of a candidate for triple therapy, the patient's history must be taken, a physical

examination made, viral load, CT4 and CT8 analyses performed; CBC measured, and SMA20, a VDRL, a hepatitis profile, and a chest X-ray made.

223. The most important factor to assess in evaluating a candidate for triple therapy is currently the viral load. If an HIV patient does not have any liver or renal disease, the patient should be given triple therapy. It is important to begin the therapy as early as possible to decrease the viral load and maintain the CT4 count (once decreased, the CT4 count does not recover, and the only way to preserve the CT4 count is to decrease the viral load).

224. "Triple therapy" for HIV+ consists of the administration of a combination of antiviral medications. If triple therapy doses are not administered correctly, a patient's HIV infection can develop resistance to the medications included in triple therapy. "Resistance" occurs when an organism develops a mutation that makes it immune to or less affected by a drug. Triple therapy represents a substantial advance in the treatment of people with HIV because it decreases mortality, decreases opportunistic infections, decreases hospital admission rates, decreases viral loads, improves the immune system, and improves the quality of life for HIV patients.

225. To avoid the development of drug resistance by HIV, it is necessary to prescribe more than one medication. Also, the patient must take some medications at strictly prescribed times throughout the day, and cannot miss doses. This requires commitment by the patient, as well as resources by the health

provider. For example, some of the HIV medications must be refrigerated.

226. In order for triple therapy medication to be effective, the patient must take at least 90% of the prescribed doses; if less than 90% is taken, the effectiveness will decrease; if less than 60% are taken, the medication has no effect. When unit dosage delivery of triple therapy falls below 90%, CT4 counts will decrease and infections and mortality will increase. As inmates on triple therapy are transferred without records, and without an effective inmate tracking system, the CHP cannot follow patients from one institution to another. Those patients will miss dosages and the efficacy of the medication will decrease.

227. In addition to applying the medications in triple therapy to HIV patients, it is necessary to monitor CT4 counts and viral loads. Patients have to be followed very closely, especially during the first three months of treatment, because of the possible side effects of the medication. The effect of delays on initiation of treatment with triple therapy in AOC institutions will be a higher mortality rate--i.e., patients die sooner than those whose treatment begins earlier--and higher rates of opportunistic infections. As a consequence, hospital admissions will increase. On the other hand, early intervention will reduce mortality and the incidence of opportunistic infections. The delay in treatment with triple therapy also can result in increased spread of opportunistic infections among the population to inmates with HIV. There also are some diseases, such as tuberculosis, that can spread to people who are not infected with HIV.

228. Hepatitis C also poses a problem in the inmate population. To adequately treat the disease, which is spread by blood contact, it is necessary to spot it as soon as possible. Treatment requires 12 to 18 months of treatment with Interferon. Hepatitis C can lead to carcinoma or cirrhosis of the liver. There is a high prevalence of hepatitis C among the inmate population. The interferon treatment is administered once a day, seven days a week, by injection, which must be administered by a nurse.

229. The procedure for administering HIV test to inmates in the AOC system is to provide them with counseling upon admission to prison, and to ask if they want to be tested.

230. The medication for tuberculosis is applied twice a week. If this frequency is interrupted, the efficacy of the medication will decrease.

231. The lack of an inmate tracking system and the transfer of inmates without medical records also makes it difficult to effectively apply triple therapy, because the CHP cannot follow patients from one institution to another. Those patients would miss dosages and the efficacy of the medication will decrease.

232. Discontinuity in triple therapy treatment can result in a "rebound" effect, in which the HIV virus begins to reproduce much more actively, and to become drug resistant.

233. The procedure for administering HIV test to inmates in the AOC system is to provide them with counseling upon admission to prison, and to ask if they want to be tested. Some inmates refuse to be tested for HIV, however; the reasons for this refusal vary. Some inmates do not want to accept that they are in a high

risk group, some already know they are infected, some think they may be infected but do not want to face it, and some patients simply do not want to receive treatment.

Medication and Unit Dosages

234. Nor has the Program ever been able to achieve 95% successful delivery of unitary dosages of medicine. "Unitary dosages" refers to the administration of individual doses of medication to an inmate with a contagious, deadly, long term or acute condition, directly by health care staff. In certain cases, this is necessary to ensure that an inmate actually takes the medication at the prescribed time. For example, one type of medication to combat HIV must be taken every eight hours to be effective. This means not just three times a day, but actually at the end of every eight-hour period. Failure to adhere to this rigid schedule can render the medication ineffective at best. At worst, it can promote the development of drug resistant strains of HIV.

235. In the system as a whole, the percentage of unit doses actually dispensed decreased from 86.4% in 1995-96 to 85.5% in 1996-97. Individual prisons had 1996-97 compliance levels as low as 84.7% (Sabana Hoyos), 77% (Ponce), 82.3% (Zarzal), and 77.6% (Fort Allen). Exhibit 560. These compliance percentages translate into huge numbers of medication doses returned and not dispensed: 180,761 in 1995-96 and 194,406 in 1996-97.

236. These levels of noncompliance pose serious risks to patients. Patients on psychotropic medication whose mental illnesses is controlled may relapse into an acute phase. Patients taking medications for epilepsy who miss them for three days may revert to

chronic/acute phases and have convulsions. Patients on cardiac medication can suffer mild cardiac arrest or can die. The failure to provide medications as prescribed for infectious diseases such as tuberculosis, HIV and hepatitis c may not only constitute ineffective treatment but also may result in the medications becoming ineffective through the development of resistance. Triple therapy for HIV requires a 90% compliance rate to be effective.

237. The issue of returned unit doses has been discussed with nursing staff, taken to executive committee meetings with AOC staff, discussed with area superintendents and with prison superintendents, as well as with the Chief Health Care Coordinator.

238. The failure to complete unit dosages results from a number of factors. Nurses that administer unitary dosages to patients must be accompanied by a custodial officer. Because officers are not available, however, the nurses often cannot take the medications to the housing units. Transferring inmates without their medical records can interrupt the continuity of medication as well, because staff at the receiving institution do not know what diseases or medications are being taken by the inmate who is transferred. Currently, if inmates receiving unit doses are transferred from one institution to another, the nursing staff at the first institution, upon discovering that the inmate was transferred, contacts the infection control nurse, who attempts to locate the inmate at the institution to which the inmate was transferred.

239. The failure to provide unitary dosages to mental health patients results in those patients' relapsing into acute conditions. When this happens, the

entire cycle of medication must be started over again, or the patient must be sent to the Correctional Psychiatric Hospital or to the PICU.

Physical Therapy

240. For a course of physical therapy to commence, there must be a prescription from a physiatrist or an orthopedist. The delay in commencement of a course of physical therapy can perpetuate neurological damage and incapacitate the patient. At the Rio Piedras complex, it can take seven months to get an orthopedic clinic appointment, and if the patient misses the appointment for lack of a vehicle, or of a custodial officer, it can take another six months to get a second appointment.

241. The physical therapy area at the Rio Piedras Complex has the minimal equipment necessary to provide physical therapy services. But frequently, inmates who are scheduled for therapy do not make their appointments because they are not brought to the facility. Although the physical therapy services provided to inmates who have access to them are adequate, there is only one physical therapy facility in the entire AOC system.

Diets

242. The AOC does not provide inmates with special medical diets. This has been and continues to be a significant problem. There is nothing resembling a professionally acceptable medical diet program in the Puerto Rico correctional system. The CHP's responsibility with respect to medical diets is fairly limited; it is the AOC's responsibility to actually provide diets to inmates. Because of shortages of funds, the CHP can obtain special nutritional supplements for

only the most seriously ill patients. The failure to provide an appropriate diet results in a number of dangers to inmates: chronic illnesses can rapidly deteriorate, diabetics can suffer cardiovascular and neurological damage; people with high blood pressure can suffer damage to blood vessels, the kidneys, brain, heart, and run the risk of stroke.

Mental Health Services

243. Psychiatric and mental health services have suffered in particular. Psychiatric staff were able to provide treatment to only 25% of the inmates in the AOC system who require such treatment during the 1996-1997 fiscal year.

244. In the system as a whole, approximately 698 of inmates require some form of treatment for mental health conditions who are not receiving that treatment. Of these, 121 inmates require intermediate care, 464 require ambulatory care, an indeterminate number require hospitalization, and others require some other form of care. "Ambulatory" mental health services are those that can be provided on an outpatient basis. "Intermediate" mental health care requires placement in a specialized unit for mental health patients who require more intensive therapy for prolonged periods of time. Hospitalization is required for patients suffering acute psychosis. Currently, there are not enough intermediate care beds available for the inmates who require such care. The CHP also does not have sufficient psychiatric hospitalization beds for the inmates who require such services.

245. About 30% of the inmate population requires mental health services of some sort (excluding addictive disorders) according to the estimates that underlie the

Mental Health Staffing Plan. Based on need, the CHP has estimated that its mental health staff reaches about one-fourth of those persons who need care.

246. The need for mental health services has increased since the Mental Health Staffing Plan was adopted. Since then the AOC population has grown substantially, and in recent years there has been a significant increase in the number of acutely mentally ill patients requiring immediate hospitalization upon their admission to prison. T1068-69 (Dr. A. Guzman); T896-97 (Dr. A. Guzman) (citing 423 acute psychiatric patients, newly sentenced or pretrial detainees, received from court at Rio Piedras in FY 1996-97, increased from 260 the year before; noting that the problem extends beyond Rio Piedras); Plaintiffs' Exhibit 526 (showing that in FY 1996-97, of 549 person from the Rio Piedras admissions area evaluated at the PICU in Rio Piedras, 174 required admission to that unit).

247. Because of concerns about untreated mental illness, the CHP in mid-1997 initiated an "outreach" effort in which mental health staff were taken away from their regular duties and sent into the prison population to look for mentally ill persons. This effort has to date been carried out at the Ponce complex, Vega Alta, and the State Penitentiary at Rio Piedras. At these facilities, staff identified some 23 inmates who required intermediate mental health care, 88 who required ambulatory treatment, and 17 who required hospitalization. T884-85, 1071, 72 (Dr. A. Guzman); Exhibit 559; see T317 (Dr. R. Guzman) (describing outreach findings at Rio Piedras).

248. Based on these results, the CHP has estimated that extending the outreach program to the entire system would yield 121 persons requiring intermediate care, 464 requiring ambulatory care, and 89 requiring hospitalization.

249. Defendants have not been able to provide the appropriate treatment for those persons with serious mental health needs discovered in the outreach to date. Of 17 inmates who require immediate hospitalization, only 6 have been hospitalized because the defendants, citing lack of security staff, have permitted Dr. Guzman to open only one of the wards in the Correctional Psychiatric Hospital. The remaining patients have been waiting two to three months for hospitalization. Ordinarily, patients who are identified as needing hospitalization must be admitted immediately. Some of these patients have been repeatedly referred to the Psychiatric Intensive Care Units when they decompensated. At times there have been as many as 20 patients competing for the 14 beds in the Rio Piedras PICU, with the overflow being held in the hallways.

250. No date has been set for opening the additional wards to provide room for these patients (or the dozens of other persons needing hospitalization that will likely be discovered when the outreach effort continues). The psychiatric hospital was to have been opened by July 1, 1993. Mental Health Plan at PII.D.16. The partial opening took place on August 1, 1996.

251. The prison system's mental health staff is far lower than the levels required by the Mental Health Staffing Plan, and the shortfall has worsened rather than improved. Recruitment of mental health staff, especially psychiatrists, is difficult because they are

concentrated in metropolitan areas and because the program has great difficulty competing with the private sector, the health reform, and ANSCA, the new addition agency. Salaries are unattractive and persons working on contract receive no fringe benefits.

252. Of a required total of 177.32 full time equivalents mental health staff, the number actually employed reached a total of 94.54 in 1996 but has fallen to 80.6 in 1997.

253. The greatest shortfalls are in psychiatrist and psychologists. Of 35.89 psychiatrists required, the number employed reached a peak of 12.79 in 1995 and fell to 9.9 in 1997. Of 90.14 psychologists required, the program employed 37.27 in 1996, and in 1997 employed 30.8.

254. These shortfalls are further broken down for each professional category among ambulatory, intermediate and admissions services in Exhibits 571-579; T878-80 (Dr. A. Guzman). In no instance does the number employed in 1997 equal the number required, and in every instance the 1997 figure represents a decline from the previous year. At the hearing, Dr. Guzman testified that since Exhibit 570 was prepared, the program has lost another three psychiatrists.

255. At Ponce, the psychiatric staff is inadequate, with only one psychiatric assigned to ambulatory services and referrals from admissions and another assigned to the intermediate units. Dr. Ramos testified, "Yes, we don't fully serve the mental health patients, specially in terms of their evaluation month by month and also the medication that has to be served to them."

256. At Rio Piedras, Dr. Rafael Guzman linked inadequate mental health staffing to the failure to

evaluate patients and to adjust their medication properly, resulting in deterioration in their mental condition, as demonstrated by the results of the mental health outreach effort. He added that "we are usually brought the patients who have disciplinary problems bu the patient who is depressed, who is isolated, who is not bothering anybody, that patient is not making it to us and we are not making it to them."

257. Untreated mental illness in a prison setting presents risks both to the mentally ill and to those around them in the prison population, since their disorders may render them either fragile and vulnerable or aggressive. There may be physical abuse of the vulnerable mentally ill prisoner by other inmates because their behavior is unruly and their presence is obnoxious. They create management problems for the staff in housing units. Mental illness itself is a catastrophic illness that is extremely painful for the person experiencing it. Some mentally ill persons are at risk of suicide if not treated.

258. Some untreated mental illness results from prisoners' being transferred out of admissions areas before their assessments are completed. In some such cases, the Correctional Health staff are first notified of the patient when he has decompensated.

259. The risks of inadequate mental health staff are illustrated by the case of the patient admitted to Ponce for a motor vehicle violation, with a history of mental health problems and in a state of drug withdrawal, at a time when there was no psychologist on duty; he committed suicide the next day.

260. The number of suicides in the AOC population has varied from 8 to 11 during the last four fiscal years.

This appears to be a high suicide rate. Dr. Shansky testified that in Illinois, there were two or three suicides a year in a population that varied from 25,000 to 30,000. In the District of Columbia, there was previously a high rate (8 or 9 in a population of 1700), but it has been reduced to one suicide in the two years he has been receiver.

261. Defendants' mental health program is deficient in facilities or operations in a number of other respects.

262. Correctional Regional Mental Health Units (CRMHU) are to be established at the regional intake centers. Mental Health Plan at PI.3. Each CRMHU is to maintain a Psychiatric Intensive Care Unit (PICU). There should be 25 beds. In fact, there are only 20 beds in three PICUS: 14 beds at Rio Piedras, 4 at Vega Alta and 2 at Ponce. Sabana Hoyos and Bayamon do not have PICU units. Nor have there been PICU beds at Mayaguez, though it was initially designated an intake center.

263. The number of PICU beds in completely inadequate. However, because of the loss of medical dormitory beds because of remodeling, construction defects, and AOC crowding and security demands, the Chief Health Care Coordinator has proposed utilizing one of the presently closed wards of the Correctional Psychiatric Hospital as a PICU and devoting the existing PICU beds to use as medical dormitories in light of the major loss of medical dorm beds to remodeling and AOC crowding and security demands. No action has been taken on this proposal.

264. The Mental Health Plan requires each CRMHU to maintain a psychosocial unit for persons needing intermediate mental health care, i.e., chronic mentally

ill persons who do not require hospitalization but must be separated from the general population. Mental Health Plan at P II.C.12. These are patients who inter alia must be taught daily living skills, the use of medication, and how to recognize their symptoms and ask for help.

265. While these intermediate units exist, except at Sabana Hoyos, they are not operated consistently with their purpose. In the Rio Piedras 504 building, there is a Psychosocial Intermediate Area with two living modules of 24 cells each. However, it is located far from the medical staff and there is no nursing station in the area. Correctional Health staff must rely on custodial staff to give them access, and sometimes custodial staff are not available, resulting in limitation of services to this vulnerable population. This lack of security coverage is detrimental to the population, since they have chronic psychiatric disorders and need constant supervision to perform the tasks of everyday living. T285-87 (Dr. R. Guzman); see Plaintiffs' Exhibit 524 (letter from mental health staff to AOC security supervisor, noting dangers of lack of security coverage including other inmates' coming into the unit and selling razors to the mental health patients, some of whom cut themselves with razors). There is also no running water in this unit.

266. Similarly, at Bayamon, the intermediate psychosocial unit, Dorm 5C, lacks adequate correctional staff to supervise the unit, resulting in inability of nurses and other personnel to visit the unit to do their work. Dr. Torres testified that routinely on weekend nights, he would encounter the nurse assigned to the intermediate unit in the medical area rather than at her post because lack of custodial staff meant that she could

not get to the unit. As a result, the patients cannot get their medication, most of which is unit doses. This lack of supervision poses risks to the patients' health and safety. Without supervision, there are fights, and there has been sodomy in a population that includes persons with HIV infection. If these patients, whose mental conditions have been stabilized, do not receive their medication as prescribed, they may revert to an acute state. Some of these patients have suicidal ideation. Dr. Torres cited the example of a patient who got out of the unit onto the roof, threatened suicide, and cut himself on barbed wire. This is the kind of behavior that interruption of medication may cause.

267. At Ponce, there is an intermediate psychiatric area for young adults, the only one in the system. The staffing of this unit is inadequate, resulting in harm to the patients and frustration to the staff.

268. In some instances AOC has placed prisoners in intermediate psychiatric areas who do not meet the criteria for placement in them. These areas are carried on the AOC census as if they were general population housing areas.

269. One psychiatric population for whom no provision at all is made is a group, now numbering 26, of persons with severe antisocial personality disorder. These prisoners have long histories of criminal activity and have brief psychotic episodes and depressive episodes with suicidal conduct and acts of self-mutilation. They are not appropriately housed in a psychiatric hospital or an intermediate care unit because their behavior is abusive to other people and disruptive to an intermediate program. They require a secure unit with a solid mental health component and

appropriately trained security staff. Dr. Guzman's requests to successive AOC administrators concerning this population have gone unanswered, except for the present administrator's suggestion that she set up a committee.

270. The CHP cannot provide mental health services to the population that requires such services. During the fiscal year 1996-1997, CHP psychiatrists saw only 6.7% of the inmate population, compared to an estimated 27.2% of the population who require psychiatric services. Thus, CHP psychiatrists saw only 25% of the target population. In real numbers, this means that CHP psychiatrists were able to see only approximately 775 inmates out of an estimated 3,158 who needed psychiatric services. Much of the failure to treat mental health illness in the system results from shortages in mental health staff. The demand for mental health staff has increased within the AOC since 1993, in part because of an increase in the inmate population, but also because of an increase in the number of acute psychiatric cases being admitted from the free community.

271. Out of approximately 177 full time mental health staff required by the CHP in 1993, the program had only 52.5. That number increased to approximately 94.5 by 1996, but fell again during 1997 to 80.6. Out of approximately 51 full time social workers required by the CHP in 1993, the program had only 20.6. This number rose to approximately 45 in 1996, but fell again to approximately 40 in 1997. Out of approximately 90 full time psychology staff required by the CHP in 1993, the program had only 22.27. This number rose to 37.27 in 1996, but fell again in 1997 to 30.8. Out of approximately 35.9 full time psychiatric staff required

by the CHP in 1993, the program had only 9.63. This number rose to 12.79 in 1995, but had fallen to below 9.9 by 1997. Out of approximately 134.5 full time ambulatory mental health services staff required by the CHP in 1993, the program had only approximately 32. This number rose to 65.72 in 1996, but had fallen to approximately 58 in 1997. Out of approximately 36 full time social workers required for the ambulatory mental health services of the CHP in 1993, the program had only 15.6. This number rose to approximately 29 in 1996, but fell to approximately 28 in 1997. Out of approximately 65.5 full time psychologists required for the ambulatory mental health services of the CHP in 1993, the program had less than one. This number rose to 26.07 in 1996, but fell to 2.3 in 1997. Out of approximately 32.7 full time psychiatrists required for the ambulatory mental health services of the CHP in 1993, the program had only 7.51. This number rose to approximately 11 in 1995, but had fallen to approximately 9 in 1997. Out of approximately 21.4 full time staff members required for intermediate mental health services in the CHP in 1993, the program had only approximately 12. This number rose to 20.45 in 1995, but had fallen to approximately 13 in 1997. Out of 15 full time social workers required for intermediate mental health services in the CHP in 1993, the program had only 5. This number rose to 15 by 1996, but had fallen to 11 by 1997. Out of approximately 3 full time psychologists needed for intermediate mental health services in the CHP in 1993, the program had approximately 5. This number had fallen to less than 1 by 1997, however. Out of approximately 3 full time psychiatrists needed for intermediate mental health services in the CHP in 1993, the program had only approximately 2. This number had fallen to 1 by 1997.

Out of approximately 21 full time mental health personnel required for admissions services in the CHP in 1993, the program had only 8.67. This number rose to 11 in 1995, but had fallen to 9.6 by 1997. (These numbers are stated in terms of full-time equivalents.)

272. Because of limitations in staffing, there is a substantial amount of untreated mental illness in the AOC system. Patients are not being evaluated and their mental conditions are deteriorating. In many instances, psychiatric patients requiring hospitalization have been sent to the psychiatric intensive care unit (PICU) for emergency treatment. After being stabilized, however, they are released to the general population, where they decompensate, requiring that they once again be sent back to PICU.

273. The failure to provide adequate mental health treatment to an inmate can have a number of results: the inmate can be vulnerable to physical abuse by other inmates; the inmate can cause problems for the general population and staff because the inmate can become disruptive; the inmate diverts the attention of prison staff, so that they cannot deal with other problems; the inmate suffers a great deal of psychic pain because of the illnesses affecting him or her. In addition, if the inmate suffers from depression or has suicidal ideation or a history of previous suicide attempts, the inmate can harm him- or herself. Untreated mental illness in an inmate creates the potential for an increase in the number of suicides. In fiscal year 1996-1997, the AOC system had eleven reported suicides: a fact we reiterate because it is utterly unacceptable.

274. Consolidating emergency mental health care services at the Correctional Psychiatric Hospital would

allow the CHP to render better services to the inmate population. If 14 beds at the PICU in Rio Piedras can be freed by using the Correctional Psychiatric Hospital for emergency mental health services, then the former PICU beds can be used as medical dormitory beds until other beds are located elsewhere.

Testimony of Lambert N. King, M.D.

275. Lambert N. King, M.D., was qualified without objection as an expert in correctional health care and the administration of health care programs, in public institutions, not-for-profit, and for-profit corporations, as well as an expert in health care administration within correctional settings, in medical education and internal medicine. His testimony is not only valuable for whatever contributions he may offer as an expert, but for the comprehensive experience and knowledge he has in this case as an expert witness for almost two decades. He was also a member of the Health Care Executive Committee and participated in the Committee's strategic evaluation of the CHP. The court sets out his testimony separately because we take it to express the plaintiffs' position on the urgency of action by the court and for more intense court supervision in this area, Dr. King's testimony, as always, deserves the court's highest respect and credence.

276. Dr. King emphasized the main objectives that the correctional health system in the Commonwealth's prisons should be aimed at in order to provide adequate health services which will meet constitutional standards. In short, these include compliance with contemporary standards of professional practice, an emphasis on preventive services to the entire inmate population; guarantee accessibility to health care

services for all inmates; health education for the correctional population; and monitoring diagnosis and treatment of communicable diseases.

277. Dr. King pinpointed the main obstacles behind the correctional health system's inability to provide or improve the quality of the health services, or even identify and track infectious diseases: (a) budget uncertainty and unpredictability; (b) failure to contract in a stable and predictable manner for required services; (c) relentless bureaucratic and regulatory problems; and (d) the inability to ensure plaintiffs would receive specialized medical care from outside facilities, e.g., emergency, specialized and hospital care.

278. Regarding budgetary deficiencies, monitored by the Joint Health Care Executive Committee during the years 1993 through 1996, he stated: "...it was solid, a solid impenetrable wall of crisis. It was one crisis after another and not only did it have inherent problems ... but diverted the attention of the Correctional Health Program's leadership both in the central office and at the institutional levels such that it markedly compromised their ability to achieve other things that they might achieve." This handicap, which he described as fundamental, must be solved by including advance knowledge of what the budget will be, not only on an annual, but on a long term basis. T. 726. This would eliminate uncertainty in the relationships between the program and outside vendors and health services providers, such as laboratory services and pharmacy services, which must necessarily be interdependent with and have a cooperative working relationship with the program. It would also allow for the integration of the delivery system.

279. As for the administrative problems which have made it unable to function as effectively as it could, Dr. King emphatically stated: "...since 1993 the Correctional Health program and the Chief Health Care Coordinator have been submerged by a relentless and impenetrable miasma of bureaucracy which is another type of problem above and beyond the unpredictable budgets." T. 728. As a result, defendants have consistently acted to prevent the CHP from functioning properly in recruiting, contracting for, and retaining essential professional staff as well as in completing the arrangements necessary to assure access for AOC inmates to community-based emergency, subspecialty, and hospital services. Furthermore, the CHP does not have the types of contemporary information systems that are required to run a complex correctional health program. This is a very significant problem, Dr. King concludes. The bureaucratic inefficiencies confronting the program consume the attention of the leadership staff so that they cannot devote the majority of their time and energy to improve the program. Also money is wasted because the program cannot function with flexibility and the autonomy required. Therefore the CHP is trapped in a vicious cycle of inefficiency.

280. The budgetary and administrative managerial problems confronting the CHP have made it difficult to retain some of the better staff that have been recruited in the past, and have made it difficult to recruit high quality staff. He proposed the following measures to achieve the medical and mental health plans' objectives: first, to have adequate, stable, and predictable budgets; second, assure the ability to function with a minimal amount of bureaucratic interference; third, leadership of quality and integrity so that the program is identified

as a health care organization run and directed by people of the highest caliber in terms of medical and organizational expertise.

281. Dr. King also commented the possible causes and solutions to the systemic problem of failure to hire and retain health care staff. He pointed out that CHP has suffered recruitment problems particularly in the area of psychiatry. Some of the causes relate to professional compensation, which must be competitive with the market place, but such problems also relate to uncertainty about what the CHP will be in the future. That is, about the aegis under which it functions and the degree to which whatever success and vitality that the CHP has relates to the involvement of the Court.

282. Therefore, Dr. King stressed the importance of giving an assured identity and an assured future to the CHP, so that a physician or nurse or health care administrator that considers working for it will know who they are working for and will have some reasonable assurance that they can devote at least a significant portion of the professional life to the organization and program.

283. Regarding systemic problems related to proper, safe and adequate facilities, Dr. King stated that the CHP has been plagued by the types of facilities in which its staff must work. One of the manifestations of the facilities problems confronting the CHP is that the program areas are substandard, unattractive, and nonfunctional in many respects, and lack such things as sinks and private areas for interviewing patients. Many institutions are haphazardly planned and located so that there is a great deal of inefficiency and waste. Staff cannot communicate or work together effectively

and a great deal of time is wasted assuring that patients will be where they need to be at the right time and in the right place. There has been no timely progress toward the renovation and construction for the health care facilities that are needed by the CHP in order to attract and retain all necessary professional staff and to assure satisfactory and efficient medical and mental health services.

284. Far-reaching and relatively drastic measures are required to reform the CHP; these measures require some form of court intervention. To remedy and correct the situation now faced by the CHP, which was preventable, the action required must be stronger than what has been done in the past. The level of court intervention required, which should last a period of years, should be that degree that will assure that the CHP will devote itself to its mission as a health care and public health organization "without being consumed by unnecessary bureaucracy or by lack of any assurance that it will have an adequate budget in the future and by some type of mechanism that will establish the authority and the relative degree of autonomy that experts who can be relied upon will be allowed to carry out their tasks". The objective of an adequate budget process and a sense of relative permanency can be accomplished through a private not-for-profit health care corporation whose primary mission is correctional health care.

VI. DEFENDANTS AWARENESS OF PROBLEMS

285. The testimonial evidence and massive documentary evidence (together with the long history of this case), leave no doubt that the defendants have

been well aware of the problems set out above. With respect to budgeting matters, representatives of the Correctional Health Program, in addition to the Chief Health Care Coordinator, communicated in writing and in person on numerous occasions with the Secretary of Health, who also served as the Executive Director of AFASS. The Chief Health Care Coordinator, in an attempt to resolve budgetary crises, also met or communicated on numerous occasions between 1994 and 1997 with the Governor's Personal Representative and the Director of the Office of Management and Budget. Even after these attempts to resolve the budgetary problems described above, as late as fiscal year 1997-1998, the budgetary request to the Legislature for the Correctional Health Program fell far short of the program's estimated needs. The budgetary problems experienced by the Correctional Health Program have, in addition, been the subject of litigation in the Morales Feliciano case. See, for example, the discussion concerning plaintiffs' 1995 motion seeking a preliminary injunction. In addition, a letter from the Director of the Office of Management and Budget sent in February 1997 to the Secretary of Health indicates that he was well aware that the issue of adequate funding for correctional health services was a critical issue in the Morales Feliciano case. In spite of this fact, the budget request for the Correctional Health Program submitted to the legislature for the 1997-1998 fiscal year fell far short of the Program's needs.

286. Defendants also have been aware of the many problems that hinder efforts by the Correctional Health Program to recruit and maintain sufficient staff. Program personnel sent numerous memoranda to

AFASS and the Secretary of Health between 1993 and 1997 describing the difficulties encountered in recruiting staff, requesting assistance in processing contracts for professional staff, in improving benefits and pay for Correctional Health staff, and with other problems experienced by the program.

287. In addition to the foregoing, most of the problems described above have been described in reports of the Court Monitor confirmed by the court and in semi-annual reports produced by the Chief Health Care Coordinator and filed by defendants. See, for example, the Seventh Semi-Annual Report concerning correctional health care, which defendants filed in 1993 (Docket # 4620). The need for greater autonomy in the Correctional Health Program was the subject of intense negotiation in 1995 after plaintiffs filed a Petition for Preliminary Injunction to Compel Defendants to Adequately Fund the Correctional Health Care Program (Docket # 5762). These negotiations culminated in an administrative order that purported to grant the requisite authority to the Correctional Health Program, but which did not accomplish its purpose, which was evident to the Secretary of Health through numerous communications throughout the remainder of 1996 and into 1997.

288. In short, the persistence of the problems described above go beyond deliberate indifference or reckless disregard and can be ascribed to intentional acts on the part of defendants. What is not there is what the defendants have intended and still intend not to be there. It is not a question only of mere administrative incompetence, these are willed, intended results. Prejudice against inmates throughout the prison system and throughout the public health

systems is one of the factors that hinders the delivery of health care to inmates.

CONCLUSIONS OF LAW

Continuing Violations of Plaintiffs Federal Constitutional Rights

289. The uncontested facts and evidence regarding the present status or conditions of the correctional health delivery system and its administration amply support the conclusion, as a matter of law, that the plaintiff class' constitutional rights have been and continue to be violated by defendants. The record as well as the applicable law reveal that this is not a matter of simple non-compliance or default with Court Orders or Stipulations by the parties. The violations of Federal rights that are in evidence are of constitutional import and relevance as to mandate immediate remedial and injunctive action. A shift on emphasis from mere non-compliance to pervasive and continuous disregard to constitutional rights is mandatory when evaluating the legal impact of the facts supported by the record.

290. Defendants have violated plaintiffs' rights under the Eighth, Fourteenth and Fifth Amendments to the United States Constitution by failing to provide inmates with adequate and reasonable health care. See *Estelle v. Gamble, 429 U.S. 97, 50 L. Ed. 2d 251, 97 S. Ct. 285 (1976)* (Estelle).

The Unnecessary and Wanton Infliction of Pain to Plaintiffs

291. Defendants' acts constitute the unnecessary and wanton infliction of pain and violates the "cruel and

unusual punishment" component of the Eighth Amendment.

292. "The treatment a prisoner receives in prison and the conditions under which he is confined are subject to scrutiny under the Eighth Amendment". *Helling v. McKinney, 509 U.S. 25, 31, 125 L. Ed. 2d 22, 113 S. Ct. 2475 (1993)* Helling). As the Court explained in *DeShaney v. Winnebago County Dept. of Social Services, 489 U.S. 189, 199-200, 103 L. Ed. 2d 249, 109 S. Ct. 998 (1989)* (DeShaney):

> "... The rationale for this principle is simple enough: when the State by the affirmative exercise of its powers so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs-e.g., food, clothing, shelter, medical care, and reasonable safety-- it transgresses the substantive limits on state action set by the Eighth Amendment ...".

Although the Constitution does not mandate comfortable prisons, *Rhodes v. Chapman, 452 U.S. 337, 349, 69 L. Ed. 2d 59, 101 S. Ct. 2392 (1981)* (Rhodes); "...neither does it permit inhumane ones..." *Farmer v. Brennan, 511 U.S..825, 832, 128 L. Ed. 2d 811, 114 S. Ct. 1970 (1994)* (Farmer).

293. The prohibition of cruel and unusual punishment contained in the Eighth Amendment to the Constitution of the United States has been made applicable to the Commonwealth of Puerto Rico either through incorporation into the Due Process Clause of the Fourteenth Amendment or as a result of the long

history of its application in our district. *Morales Feliciano, et al. v. Romero Barcelo, et al., 672 F. Supp. 591, 616 (D. P. R. 1986)* (Morales Feliciano II). Indeed earlier in this very case, this court emphasized that the Administration of Corrections in Puerto Rico is constitutionally required to provide "'reasonably adequate [...] shelter, sanitation, **medical care** and personal safety'" under the Fifth and Eighth Amendments. Morales Feliciano (II), *Id., at 619* (emphasis added, internal citations omitted). See also, *Feliciano v. Barcelo, 497 F. Supp. 14, 33-34 (1980)* (Morales Feliciano It). In the present case, the plaintiff class is constitutionally protected under the Eighth Amendment from the denial of reasonably adequate health care. *Rhodes, 452 U.S. at 347; Estelle v. Gamble, supra.* In Morales Feliciano II the Court, citing Estelle, emphasized: "... the denial of medical care is cruel and unusual because, in the worst case, it can result in physical torture, and, even in less serious cases, it can result in pain without any penological purpose." *672 F. Supp. at 617.* Moreover, as stated by the Supreme Court in the landmark decision of Estelle "in the worst cases, [the government's failure to provide medical care for those whom it is punishing by incarceration] may actually produce physical 'torture or a lingering death[.]' " *Estelle, 429 U.S. at 103* (citations omitted).

294. Applicable constitutional interpretation of the cruel and unusual component of the Eighth Amendment has established that a violation exists when the conditions of confinement "involve unnecessary and wanton infliction of pain", or are "grossly disproportionate to the severity of the crime warranting imprisonment". *Rhodes, 452 U.S. at 347.*

295. The content of what constitutes unnecessary and wanton infliction of pain under the Eighth Amendment derives from " 'broad and idealistic concepts of dignity, civilized standards, humanity, and decency ...' ", *Estelle, 429 U.S. at 102*, quoting from *Jackson v. Bishop, 404 F.2d 571, 579 (8th Cir. 1968)*, and from "'. . . the evolving standards of decency that mark the progress of a maturing society.' " Id. quoting *Trop v. Dulles, 356 U.S. 86, 101, 2 L. Ed. 2d 630, 78 S. Ct. 590 (1958)*(Trop). The court in *Morales Feliciano II, 672 F. Supp. at 617-619*, has relied on the high penological standards set up by Article II, § § 7 and 12 of the Constitution of the Commonwealth of Puerto Rico which prohibits, among others, the death penalty as well as cruel and unusual punishment. Also, legislative enactments of Puerto Rico's Legislative Assembly specifically require that adequate medical care and hospital services be provided to the inmates as part of the contemporary values of the Puerto Rican society, which give content to the constitutional protection, from wanton infliction of pain embodied in the Eighth Amendment and its Puerto Rican counterpart. See 4. P.R. Laws Ann. § 1112(f).

Defendants Deliberate Indifference to Plaintiff Class

296. In order to prove that the defendants have violated plaintiffs' rights to be free from cruel and unusual punishment, plaintiffs must come forth with evidence sufficient to sustain that defendants acted with "deliberate indifference" toward a federally protected right. In the present case, plaintiffs' proof required a showing that defendants' actions amounted to "deliberate indifference to a serious medical need."

Estelle, 429 U.S. at 106. See; *Wilson v. Seiter, 501 U.S. 294, 299-300, 115 L. Ed. 2d 271, 111 S. Ct. 2321 (1991)* (Wilson); *DesRosiers v. Moran, 949 F.2d 15, 18 (1st Cir. 1991)*(DesRosiers). The analysis required by the standard of deliberate indifference is two-fold: 1) the **objective** component which looks at the existence of a sufficiently serious deprivation of a "single, identifiable human need" (in the present case, adequate medical care); and, 2) the **subjective** component which inquires whether the required mental state of the defendants was present in the deprivation (Was it wanton and unnecessary infliction of pain?). Wilson, at 305; DesRosiers, at 18. Plaintiffs must prove that defendants had a "culpable state of mind and intended wantonly to inflict pain." DesRosiers, at 19.

297. In order to establish that defendants wantonly and deliberately intended to inflict pain under the deliberate indifference standard of Estelle, the defendants' state of mind may be established by ". . . the official's response to an inmate's known needs or by denial, delay or interference with prescribed health care." DesRosiers, at 19, quoting *Estelle, 429 U.S. at 104-05.* Deliberate indifference may also be established in cases where the attention received by the inmate is "'so clearly inadequate as to amount to a refusal to provide essential care.'" *Torraco, 923 F.2d 231, 234,* quoting *Miranda v. Munoz, 770 F.2d 255, 259 (1st Cir. 1985)*(Miranda)).

298. Accidental or mere negligence in the provision of adequate health care to a prisoner is not sufficient for a finding of Eighth Amendment violation. *DesRosiers, 949 F.2d at 19* ("inadvertent failures to provide medical care, even if negligent, do not sink to the level of deliberate indifference")(citations omitted).

299. The evidence presented by plaintiff class amply satisfies the standards stated above, and amply establishes that defendants' actions constitute deliberate indifference to the plaintiff class' serious medical needs in violation of applicable constitutional provisions. There is substantial evidence that defendants actions or lack thereof has caused or contributed to the deaths of class members and to the infliction of pain and suffering on countless others.

Systemic Deliberate Indifference

300. In class action cases challenging the entire system, the deliberate indifference standard may be shown, as stated in *Ramos v. Lamm, 639 F.2d 559, 575 (10th Cir. 1980)* cert. denied *450 U.S. 1041, 68 L. Ed. 2d 239, 101 S. Ct. 1759 (1981):* ". . . by proving repeated examples of negligent acts which disclose a pattern of conduct by the prison medical staff . . . or by proving there are such systemic deficiencies in staffing, facilities, equipment or procedures that the inmate population is effectively denied access to adequate medical care." See *Todaro v. Ward, 565 F.2d 48, 52 (2d Cir. 1977).*

301. "...Systemic deficiencies in staffing, facilities, or procedures [which] make unnecessary suffering inevitable" constitute deliberate indifference. *Todaro v. Ward, 565 F.2d at 52,* quoting *Bishop v. Stoneman, 508 F.2d 1224, 1226 (2d Cir. 1974);* accord, *Harris v. Thigpen, 941 F.2d 1495, 1505 (11th Cir. 1991); DeGidio v. Pung, 920 F.2d 525, 529 (8th Cir. 1990)* (lack of "adequate organization and control in the administration of health services" supported finding of Eighth Amendment violation); *Free v. Granger, 887 F.2d 1552, 1556 (11th Cir. 1989)* ("Proof of staffing or

procedural deficiencies may give rise to a finding of deliberate indifference"); *French v. Owens, 777 F.2d 1250, 1254 (7th Cir. 1985)*, cert. denied, *479 U.S. 817, 93 L. Ed. 2d 32, 107 S. Ct. 77 (1986).*

302. The hearing record as a whole supports a finding of such systemic deficiencies in staffing, facilities, procedures, and administration.

303. Defendants have long been perfectly aware both of the level of care required and the level of care actually provided. During the 17 years since the Court's initial grant of relief concerning medical and mental health care, defendants' continued litigation of health care issues has enabled them to become increasingly knowledgeable of both plaintiffs health care needs and of defendants' obligations under the U.S. Constitution. Defendants have failed despite these years of opportunity, encouragement, and coercion to comply with the court's orders and establish a constitutional system of prison health care.

304. Defendants act with deliberate indifference because they are not responsive to the plaintiff class' known needs or when they deny, delay or interfere with prescribed health care due to systemic mismanagement of resources. *Estelle, 429 U.S. at 104-05; DesRosiers, supra.* The vast majority of the testimonies reveal that the defendants know and understand plaintiff class' need for adequate and basic health care but continue nonetheless to deny or delay said care wantonly and deliberately due greatly to systemic failures.

305. The combination of individualized and systemic health care conditions amount to a deprivation of prisoners' rights pursuant to applicable constitutional

provisions. The Supreme Court clarified that although some conditions of confinement alone could not amount to a deprivation of constitutional rights, others may establish an Eighth Amendment violation "'in combination' when each would not do so alone." *Wilson, 501 U.S. at 304.* Conditions of confinement "in combination" may support a finding of constitutional violation when the conditions "have a mutually enforcing effect that produces the deprivation of a single, identifiable human need such as food, warmth, or exercise ...". Id. For instance, placing a schizophrenic inmate in a badly overcrowded cell amounts to a "recipe for an explosion" and "death". *Cortes-Quinones v. Jimenez Nettleship, 842 F.2d 556, 558-560 (1st Cir. 1988),* cert. denied, *488 U.S. 823, 102 L. Ed. 2d 45, 109 S. Ct. 68 (1988)*(Cortes-Quinones).

306. Similarly, defendants' lack of adequate organization and control in the administration of health services has been noted by the Court of Appeals for the First Circuit in *Miranda, 770 F.2d at 261, fn 4:* "This is not a case in which it is inconsistent to find liability on the part of both the local prison officials and the central prison administration. A jury could have found that it was the combination of conditions authorized by the Correctional Department [sic] and specific actions taken by the Arecibo Jail Official's which caused plaintiffs' injury" (italics in original). Regarding lack of adequate organization and control in the administration of health services that are tantamount to deliberate indifference, see also: *Todaro, 565 F.2d at 52; Harris v. Thigpen, 941 F.2d 1495, 1505 (11th Cir. 1991); DeGidio v. Pung, 920 F.2d 525, 529-33 (8th Cir. 1990).*

307. In addition, defendants have consistently failed to provide adequate sanitation and security to

correctional health personnel thereby contributing to the development of hostile and indifferent attitudes toward inmates' overall health needs. The resulting circumstances no doubt amount to deliberate indifference as proscribed under the law.

308. The non-existence of an integral system or unitary institutional structure of administration and delivery of health services denies the plaintiff class or delays their access to necessary medical care in wanton disregard to basic medical and human needs, causing infliction of pain without any penological purpose. Defendants' breakdown of regularity and continuity of services, including medical services, inflicts on inmates psychological and medical harm in wanton disregard of their constitutionally protected right to reasonably adequate health care within contemporary medical standards of professional care. Such systemic deficiencies in the administration of the corrections system, especially the lack of security and the administration of the health care services constitute deliberate indifference and disregard to defendants' legal duties, in violation of the plaintiffs' constitutionally protected right to reasonably adequate health care.

309. The undisputed and uncontested facts of this case support the conclusion that defendants' acts and omissions are deliberately indifferent to basic human and health needs of inmates and that the pervasive and continuous egregious conditions in prison health facilities constitute wanton and unnecessary infliction of pain of the kind specifically proscribed by the Fifth and Eighth Amendments. *Estelle, supra.* Moreover, defendants' reckless indifference to the chaotic, isolated administration and/or mismanagement of health

services, constitute daily violations of statutory laws and regulations requiring reasonable medical care and thus, deprive inmates of their liberty without the due process of law as contained in the Fourteenth Amendment. *Cameron, supra.*

Defendants Violations of the Health Care Required by Applicable Constitutional Standards Is Egregious.

310. In the present case, the plaintiff class is constitutionally protected under the Eighth Amendment from the denial of reasonably adequate health care. *Rhodes, 452 U.S. at 347; Estelle, 429 U.S. at 103.* In the landmark Estelle opinion, the Supreme Court concluded that "acts or omissions sufficiently harmful to evidence deliberate indifference to **serious medical needs** of prisoners" violate constitutional standards for it amounted to unnecessary and wanton infliction of pain. *429 U.S. at 106* (emphasis added). The Court of Appeals for the First Circuit has defined that "serious medical need" is one "that has been diagnosed by a physician as mandating treatment, or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention". *Gaudreault v. Municipality of Salem, 923 F.2d 203, 208 (1st Cir. 1990)* (citations omitted)(Gaudreault).

311. The "seriousness" of an inmate's medical need may also be determined by reference to the effects of a delay in treatment. Gaudreault, *Id. at 208.* "Serious medical needs" also include conditions that threaten to cause health problems in the future. In *Helling, 509 U.S. at 32-33* the Supreme Court established, in the context of involuntary exposure to environmental tobacco smoke (ETS) by inmates, that the Eighth

Amendment also protects against future harm to the inmates' health.

312. In this case, the inability of health care personnel to treat Hepatitis C, to administer triple therapy to HIV+ and AIDS patients and to properly isolate cases of active tuberculosis inflicts cruel and unusual punishment on particular individuals at present, endangers their health in the future and threatens the health of all the members of the class. That this happens because defendants cannot provide security to their own personnel is all the more indicative of defendants' recklessness in the face of repeated complaints and reports about this state of affairs.

313. Serious medical needs refer indistinctly to mental and physical ailments. It is well settled law in the First Circuit that the Eighth Amendment also protects against deliberate indifference to an inmate's serious **mental** health and safety needs. *Cortes-Quinones, 842 F.2d at 560.* The extension of the Eighth Amendment protection from physical health needs, as presented in Estelle, to mental health needs is appropriate according to First Circuit standards due to the fact that there is "'no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart.'" *Torraco v. Maloney, 923 F.2d 231, 234 (1st Cir. 1991)* (citations omitted)(Torraco).

314. The evaluation of the adequacy of health care revolves around the inquiry of whether the services are ". . . at a level reasonably commensurate with modern medical science and of a quality acceptable within prudent professional standards." *U.S. v. DeCologero,*

821 F.2d 39, 43 (1st Cir. 1987)(DeCologero). The standard of care does not include the "most sophisticated care that money can buy", DeCologero, *Id. at 42*, but only that which is reasonably appropriate "within modern and prudent professional standards" in the field of medicine and health.

315. As the record shows, defendants have continuously acted with deliberate indifference toward the standards of care "within modern and prudent professional standards" by delaying or denying access to medical attention to serious and urgent medical needs of inmates, all this without any penological purpose. *Estelle, supra.* The record is full of instances showing failure by defendants to take the necessary steps to provide access or avoid delay in access to medical and health care as, for example, failure to make provision for triple therapy for HIV+ and AIDS patients; insufficient medical dormitory beds for patients who require close medical supervision; the placement of patients with chronic illnesses in camps that lack the medical facilities they need; unwarranted delay in providing transportation to emergency facilities, and the long delays in scheduling specialty care appointments and the failure actually to comply with them, which constitutes a denial of access to such specialized care. *Waldrop v. Evans, 871 F.2d 1030, 1036 (11th Cir. 1989).* See also, *Inmates of Occoquan v. Barry, 717 F. Supp. 854, 867 (D.D.C. 1989)* (Inmates of Occoquan)(where deliberate indifference was shown by defendants' failure to have a follow up system for treating chronic diseases).

316. The record in this case includes yet other forms of deliberate indifference by defendants to the required standards of professional of care. As the findings clearly

reveal, defendants have also neglected to fully screen incoming inmates for infectious diseases such as tuberculosis or to detect mental health problems. Such or similar omissions have been held to violate the Constitution in *LaReau v. Manson, 651 F.2d 96, 109 (2d Cir. 1981); Inmates of Occoquan, supra; DeGidio, 920 F.2d at 529-33.* The record further evinces that defendants, as a matter of course, fail to inquire into essential facts and fail to conduct routine tests necessary to provide adequate medical care. Likewise, the record illustrates defendants' failure to inquire about the inmates' prior medical history.

317. Defendants have failed to provide for a sick call system that ensures access to care and that is capable of effectively handling emergencies. By so doing, defendants endanger the lives of the inmates by denying or delaying access to health care. In the Seventh Circuit this type of deficiency supported a finding of deliberate indifference. See, *Bass v. Wallenstein, 769 F.2d 1173, 1184-86 (7th Cir. 1985); Inmates of Occoquan, supra, at 867* (deliberate indifference shown by sick call system which relied heavily on medical technical assistants by allowing them to diagnose and dispense medication without proper supervision by trained medical staff).

318. Similarly, the failure to carry out medical orders by neglecting to provide prescribed medication or disregarding special recommendations for surgery or specialized care, when officials are subjectively aware of conditions requiring intervention, is deliberate indifference according to *Mahan v. Plymouth County House of Corrections, 64 F.3d 14, 18 (1st Cir. 1995).*

319. Another recognized form of deliberate indifference is "intentionally interfering with the treatment once prescribed." *Estelle, 429 U.S. at 105.* Examples of this form of deliberate indifference are the failure consistently to administer "unit dose" medication, the failure to provide transportation to scheduled specialty appointments and physical therapy, and the failure to provide prescribed medical diets.

320. Defendants' manifest inability to adequately train, supervise or retain health care personnel which results in rampant under-staffing and the consequent impossibility to adequately meet the needs of the inmate population constitute deliberate indifference towards the health care needs of the plaintiff class. In *Newman v. Alabama, 503 F.2d 1320, 1331 (5th Cir. 1974)*, cert. denied *421 U.S. 948, 44 L. Ed. 2d 102, 95 S. Ct. 1680 (1975)*, the Fifth Circuit held that "the inexorable nonattention and delays in receiving treatment attributable to personnel shortages, the ill-conceived system for referrals of inmates ... from other facilities, and the maladroitly operated 'emergency' referral system also present grave constitutional problems." For a discussion of the nature and consequence of insufficient or inadequate mental health staff. See *Greason v. Kemp, 891 F.2d 829, 838 (11th Cir. 1990);* See also Inmates of Occoquan, at 868.

321. As the testimony of Dr. Aida Guzman reveals, severely mentally ill patients (a population that has significantly increased in recent years) continue to cohabit with the general population without being tendered any type of mental health treatment. In *Cortes-Quinones, 842 F.2d at 560-61*, this was found to violate the Constitution. See also, *Inmates of Occoquan, 717 F. Supp. at 868* (housing mentally ill inmates with

punitive segregation inmates violated Eighth Amendment rights of inmates).

322. In addition, defendants' admitted failure to hospitalize inmates whose mental health condition require the therapeutic environment of a mental health treatment facility constitutes deliberate indifference to an inmate's health care needs. Arnold on behalf of *H.B. v. Lewis, 803 F. Supp. 246, 257 (D. Ariz. 1992).*

323. Moreover, defendants have admitted to the repeated failure to timely provide necessary medical care outside their facilities, when not available internally, due in part to lack of personnel or transportation means. Evidence exists on the record showing that delays have endangered the life of inmates. This not only falls considerably short of acceptable professional standards but has also expressly been held to violate the Constitution. *Miltier v. Beorn, 896 F.2d 848, 853 (4th Cir. 1990); Inmates of Occoquan, supra.*

324. Constitutional violations by defendants are further evidenced by their failure to provide and maintain adequate facilities and equipment necessary for the provision of adequate health care of inmates pursuant to acceptable professional standards. It is undisputed that defendants have consistently failed to provide adequate sanitation and security measures to correctional health personnel, thereby contributing to the development of hostile and indifferent attitudes towards inmates overall health needs. When combined with other constitutional violations, the state of deterioration and unfitness of correctional health facilities and equipment further reinforce the deep-seated deliberate indifference of defendants toward the

inmates' constitutionally protected rights. *Langley v. Coughlin, 888 F.2d 252, 254 (2d Cir. 1989); Williams v. Edwards, 547 F.2d 1206, 1216-17 (5th Cir. 1977); Newman, 503 F.2d at 1331; Morales Feliciano It, 497 F. Supp. at 34.*

325. Furthermore, the upkeep, administration and transfer of medical records by defendants is yet another of their indisputable constitutional shortcomings. Defendants have shown a manifest ineptitude in maintaining adequate medical records that are available to health personnel when needed. *Miranda supra, at 261; Brown v. Coughlin, 758 F. Supp. 876, 882 (S.D.N.Y. 1991); Burks v. Teasdale, 492 F. Supp. 650, 676 (W.D. Mo. 1980); Inmates of Occoquan, supra.* Systemic deficiencies related to management of medical records obstructs good patient tracking within the system, affects the continuity of care and therefore impedes the adequate delivery of health care in violation of the plaintiffs' constitutional rights.

326. In addition, the defendants' failure to provide necessary medical diets has been held as deliberate indifference. *Kyle v. Allen, 732 F. Supp. 1157, 1159 (S.D. Fla. 1990); Johnson v. Harris, 479 F. Supp. 333, 336-37 (S.D.N.Y. 1979).* Budgetary limitations or inadequate resources, as alleged by defendants in this case, can never be a valid justification for constitutional violations as the court has determined. *Morales-Feliciano v. Hernandez-Colon, 697 F. Supp. 26, 35 (D.P.R. 1987).*

327. The undisputed facts of this case support the conclusion that defendants' acts and omissions, separately and in combination, are deliberately indifferent to basic human and health needs of inmates

and that the pervasive and continuous egregious conditions in prison health facilities constitute wanton and unnecessary infliction of pain of the kind specifically proscribed by the Fifth and Eighth Amendments. *Estelle, supra.* The evidence presented at trial incontestably established that defendants are perfectly aware both of the level of care required and the level of care actually provided. No surprise or ignorance may be claimed before a factual situation that has been well documented since the initial stages of this litigation as corroborated by the decisions previously rendered by this court.

328. A number of specific practices or failings shown by this record are identical or similar to matters that have been held to violate the Constitution. These include:

a. The failure to screen incoming inmates for infectious diseases including tuberculosis. *LaReau v. Manson, 651 F.2d 96, 109-11 (2d Cir. 1981).*

b. The failure to provide access to specialized care required by a prisoner's medical condition. *Howell v. Evans, 922 F.2d 712, 723 (11th Cir. 1991)* (failure to provide access to a respiratory therapist could constitute deliberate indifference), vacated as settled, *931 F.2d 711 (11th Cir. 1991); Waldrop v. Evans, 871 F.2d 1030, 1036* (11th Cir.) (non-psychiatrist was not competent to evaluate significance of a prisoner's suicidal gesture; prison officials must "inform competent authorities" of medical or psychiatric needs) (emphasis supplied), rehearing denied, *880 F.2d 421 (11th Cir. 1989); Tillery v. Owens, 719 F. Supp. 1256, 1307 (W.D.Pa. 1989)* (services of cardiologist and

dermatologist should be provided), aff'd, *907 F.2d 418 (3d Cir. 1990).*

c. The failure to provide a sick call system that ensures that prisoners receive needed care. *Bass by Lewis v. Wallenstein, 769 F.2d 1173, 1184-86 (7th Cir. 1985)* (known deficiencies in sick call system supported a finding of deliberate indifference).

d. The failure to provide mental health staff adequate to meet the needs of the population. *Greason v. Kemp, 891 F.2d 829, 837-40 (11th Cir. 1990)* (prison clinic director, prison system mental health director, and prison warden could be found deliberately indifferent based on their knowing toleration of a "clearly inadequate" mental health staff); *Cabrales v. County of Los Angeles, 864 F.2d 1454, 1461 (9th Cir. 1988)* (under staffing such that psychiatric staff could only spend "minutes per month" with disturbed inmates was unconstitutional), vacated, *494 U.S. 1091 (1989)*, reinstated, *886 F.2d 235 (9th Cir. 1989)*, cert. denied, *494 U.S. 1091 (1990).*

e. Leaving severely mentally ill prisoners in general population without mental health treatment. *Cortes-Quinones v. Jimenez-Nettleship, 842 F.2d 556, 560-61 (1st Cir. 1988)*, cert. denied, *488 U.S. 823 (1988).*

f. The failure to hospitalize prisoners whose mental health condition requires hospitalization. Arnold on behalf of *H.B. v. Lewis, 803 F. Supp. 246, 257 (D.Ariz. 1992).*

g. The failure timely to provide necessary medical care outside the prison when it is not available within the prison. *Kaminsky v. Rosenblum, 929 F.2d 922, 927 (2d Cir. 1991)* failure to act on recommendation of immediate hospitalization); *Miltier v. Beorn, 896 F.2d*

848, 853 (4th Cir. 1990) (failure to act on a recommendation for transfer to a cardiology unit); *Washington v. Dugger, 860 F.2d 1018, 1021 (11th Cir. 1988)* (failure to return patient to VA hospital for treatment for Agent Orange exposure); *Inmates of Occoquan v. Barry, 717 F. Supp. 854, 867 (D.D.C. 1989)* (Eighth Amendment violation found in part because "inmates wait months for appointments to specialty clinics"); *United States v. State of Michigan, 680 F. Supp. 928, 1002 (W.D.Mich. 1987)* (prison officials "may not allow security or transportation concerns to override a medical determination that a particular inmate is in need of prompt treatment and must be transported to an appropriate facility.").

h. The failure to provide adequate facilities and equipment for necessary medical care. *Langley v. Coughlin, 888 F.2d 252, 254 (2d Cir. 1989); Inmates of Allegheny County Jail v. Wecht, 874 F.2d 147, 153 (3d Cir. 1989)* (inadequate space for mental health facilities supported an order closing the jail), vacated and remanded on other grounds, *110 S. Ct. 355 (1989); Newman v. Alabama, 503 F.2d 1320.* 1331 (5th Cir. 1974); *Tillery v. Owens, 719 F. Supp. 1256, 1307 (W.D.Pa. 1989)* (condemning infirmary's lack of space, unsanitary conditions, and deficiencies in equipment and supplies), aff'd, *907 F.2d 418 (3d Cir. 1990).*

i. The failure to ensure that medical records are available to practitioners treating the prisoner. *Miranda v. Munoz, 770 F.2d 255, 261 (1st Cir. 1985)* (prison officials' knowledge of continuing problem of prisoners arriving at hospital without their medical records cited as a basis for damage liability); *Brown v. Coughlin, 758 F. Supp. 876, 882 (S.D.N.Y. 1991)* ("failure to transfer necessary medical records in a

timely fashion" supported a deliberate indifference claim); see *Burks v. Teasdale, 492 F. Supp. 650, 676 (W.D.Mo. 1980)* and cases cited (noting that medical records are essential to continuity of medical care).

j. The failure to provide necessary medical diets. *Kyle v. Allen, 732 F. Supp. 1157, 1159 (S.D.Fla. 1990); Balla v. Idaho State Bd. of Corrections, 595 F. Supp. 1558, 1574-75 (D.Idaho 1984); Johnson v. Harris, 479 F. Supp. 333, 336-37 (S.D.N.Y. 1979).* The facts of this case indisputably sustain the conclusion that defendants have deprived and continue to deprive the plaintiff class of reasonably adequate health care within modern and prudent professional standards of care. The vast majority of the testimonies reveal that the defendants know about the plaintiff class' need for adequate and basic health care but continue to deny or delay said care wantonly and deliberately due to systemic failures. Yet, defendants' reckless and deliberate indifference to the chaotic, isolated administration and/or mismanagement of health services, constitute daily violations of statutory laws and regulations requiring reasonable health care and thus, deprive inmates of their liberty without the due process of law as contained in the Fourteenth Amendment. *Cameron, 990 F.2d 14, 18.*

329. Defendants' chaotic and arbitrary administration of the correctional health system, the absence of standards and daily violations of statutory law in the area of health care as well as the failure to provide for proper sanitation or a safe environment, have also produced a deprivation of liberty interests of inmates without due process of law under the Fourteenth Amendment to the Constitution of the United States, as ruled by this Court since 1980 and specifically on 1986. *Morales Feliciano It, 497 F. Supp.*

at 18 (1980); Morales Feliciano II, 672 F. Supp. at 620-621. According to applicable case law from the Court of Appeals for the First Circuit, the Due Process Clause of the Fourteenth Amendment prohibits a state from extending an inmate's detention indefinitely and limits the state's capability to worsen an inmate's condition. The Due Process clause mandates a state to balance the competing demands and interests properly after which a state correctional facility may not choose alternatives or provide for circumstances that unwarrantedly lengthen an inmate's term. *Cameron v. Tomes, 990 F.2d 14, 21-22 (1st Cir. 1993)* (Cameron). The plaintiff class has brought forth ample evidence that it has a cognizable claim under the Fourteenth Amendment since the defendants' "ordinary procedures and constraints affirmatively and needlessly worsen their mental health condition, such that members of the class might well be confined long after their sentences" expire due to the wanton and reckless infliction of pain and suffering during their imprisonment. Cameron, *Id. at 18.*

330. This court's conclusions are not altered by the undoubtedly sincere good intentions expressed on the witness stand by the outgoing Secretary of the Treasure, nor by the commitments he made as the Governor's expressly authorized representative, nor by the assurances of defense counsel on behalf of the government, nor by actions taken in the weeks before the hearing. The court has heard such professions before, and after the passage of years of noncompliance, the dispositive factor must be the long-standing failure to achieve compliance. See *Dixon v. Barry, 967 F. Supp. 535, 553-54* (activity and promises of improvement in response to receivership motion are insufficient to

avert appointment of a receiver); *LaShawn A. v. Kelly, 887 F. Supp. 297, 315* ("While it is true that the defendants have made some progress in various areas, the [court's] factual findings show the urgent need for a new, more fundamental approach to change. Otherwise, each report of incremental progress will be mitigated by regression in another area or future inaction on that first step forward. Much of the progress originally made is now slipping back into the same tired way of doing business that brought these parties before the Court."); *Wayne County Jail Inmates v. Wayne County Chief Executive Officer, 178 Mich. App. 634, 444 N.W.2d 549, 560* (same conclusion as to "flurry of compliance activities" in response to receivership motion).

331. The facts the court has found in this case, are supported by ample evidence, and show without doubt that the defendants in this case have failed in their constitutionally required obligation to provide inmates reasonably adequate medical care, as well as reasonably adequate shelter, sanitation and personal safety, under the Eighth, Fifth and Fourteenth Amendments to the Constitution of the United States. As result, the plaintiff class is entitled to continued federal injunctive relief for the protection of their constitutional rights.

REMEDY

332. Therefore the court holds that it is necessary, to protect the members of the plaintiff class from cruel and unusual punishment through constitutionally unacceptable health care services, to continue in full force that part of the Order Directing Partial Judgment filed January 22, 1996, (Dkt. 6091) and the Partial Judgment entered on January 24, 1996, (Dkt. 6093)

which relates to health care. This remedy extends no further than is necessary to correct the violation of the Federal rights of members of the plaintiff class. The court finds that such relief is narrowly drawn and certainly extends no further than is necessary to correct the violation of plaintiffs' Federal rights. There is no less intrusive means to correct the violation of plaintiffs' Federal rights.

333. The court further finds that the conditions described above are a danger to public health and security and that Puerto Rico's criminal justice system can only be improved by the implementation of the court's prior orders and judgment. Cost saving efficiency and institutional security will result from the implementation of those orders and judgment.

334. The court at this time will not decide whether or not to appoint a receiver, and under which circumstances and conditions such a receiver can and should be appointed. But the court must take the necessary steps to assure that its orders and judgment are obeyed and that the violations of plaintiffs' Federal rights cease. To do so the court will build on the remedial structure that is already in place.

335. The Medical Plan at paragraph 49, page 20 established that

> Within 90 days, the DOH shall prepare and submit to the Central Personnel Office (OCA) a reimbursement schedule for physicians, dentists and nurses whose services are required to achieve the purposes and objectives of this Medical Care Plan. The schedule, a copy of which shall be

> filed with the Court, shall take into consideration travel allowance, malpractice insurance, and continuing medical education. The reimbursement schedule for professionals shall be at a level sufficient to recruit and retain qualified professional staff including specialists. (Emphasis added.)

336. The parties have jointly requested an order to allow the Chief Health Care Coordinator untrammeled authority to process.

337. The Hon. Manuel Diaz Saldana, then Secretary of the Treasury, now Comptroller of Puerto Rico, deprecated the ruling by the former Comptroller that the Correctional Health Program could not contract "on-call" physicians. He also stated that the delays on requesting bids and awarding contracts were unacceptable.

338. In their Joint Proposal Concerning the Correctional Health Program of September 26, 1997 (Dkt. 6673) at paragraph 12, pages 7-8, the parties agreed that

> The success of any effort to provide constitutionally-mandated health care to the plaintiff class will require coordination and support from the Administration of Correction. In 1994, the parties incorporated into the Stipulation Regarding Custodial and Sociopenal Staffing (Docket # 5241) a provision that defendants would "assign a permanent cadre of medical security personnel to occupy intra-institutional escort posts, extra-institutional escort posts, and general medical security posts, which

include manning medical dormitories, medical areas, psychiatric care centers, and drug abuse treatment areas." It is crucial that the provisions be implemented as part of the overall solution to the health care problems confronting the plaintiff class. The implementation of these provisions will require that the following steps be taken in preparation:

a. The Executive Director of the CHP and the parties will confer with consultants to determine the selection, training, and qualifications necessary for a medical cadre.

b. The recruitment and training of the medical cadre must be coordinated with the Administrator of Correction.

c. A specialized training program for the officers who will make up the medical cadre (and for those officers who will be assigned to the cadre in the future) must be developed.

d. The parties will respectfully request that the Court provide necessary funding for developing the cadre and one year of supplemental compensation for the members of the cadre, in

addition to the regular salary paid by AOC, with the understanding that following that first year, defendants will be responsible for paying any differential accorded to the members of the cadre.

339. In the same Joint Proposal the parties agreed upon a schedule for setting up the private not-for-profit corporation proposed by plaintiffs and embraced by defendants. So far the court has been advised at an informed status conference only that the incorporation papers have been filed with the Department of State of Puerto Rico. Every other deadline on the parties' joint submission has gone by with no action that the court is aware of. The court is particularly concerned about budgeting and not less concerned about the proposed not-for-profit corporation.

340. The court will at this time take interim measures and pursue the path which it deems necessary to protect the plaintiffs' rights and take some of the steps proposed by the parties. The court expects obedience now. The parties are all on notice that should the court be disappointed in its rightful expectations, it will not hesitate to reach the ultimate issues raised in this matter.

IT IS NOW ORDERED AND ADJUDGED that the Partial Judgment entered on January 26, 1996, be continued in full force and effect with respect to all health care issues, and all orders set out in the Order Directing Partial Judgment be also continued in full force and effect. And it is further

ORDERED that the Joint Health Care Coordinator shall submit directly to the court, over her signature, and to counsel for the parties, as soon as feasible, a compensation scale for Correctional Health Program employees, which meets the criteria of the Medical Health Plan set out above, including compensation for "on-call" physicians. This compensation scale should be implemented for the present contracting cycle. And it is further

ORDERED that counsel for defendants, through the Attorney General if necessary, shall seek a reconsideration of the Comptroller's ruling on "on-call" physicians. And it is further

ORDERED that the Chief Health Care Coordinator shall submit to the court, as soon as practicable, over her signature, and shall serve on counsel for the parties, an itemized list, with the approximate cost of all vehicles needed by the Correctional Health Program. And it is further

ORDERED that within thirty (30) days of the entry of this order the Executive Director of the Correctional Health Program shall submit to the Administrator of Corrections a detailed schedule of the Program's security staffing needs, including ambulance drivers and drivers and escorts for transportation medical appointments outside the institutional setting. The Administrator of Corrections shall meet with the Program's Executive Director and counsel for the parties within five (5) working days of receipt of the Executive Director's communication to discuss the development and implementation of the medical cadres agreed upon by the parties. Counsel for the parties are directed to inform the court in writing of any progress

or obstacles they meet with in the implementation of this agreement. The court deems this a matter of the greatest urgency. And it is further

ORDERED that within thirty (30) days of the entry of this Opinion and Order the Chief Health Care Coordinator will submit a report to the court over her own signature, and serve upon counsel for the parties, to inform the court on progress or obstacles the Program has encountered in the present administrative arrangements concerning payroll, services contract payments, acquisitions, bidding procedures, etc. The Chief Health Care Coordinator shall also include the Program's budgeting expectations, based on the information provided to her or to the Executive Director. The Chief Health Care Coordinator shall specifically address the budgetary needs for mental health care and the full operation of the Correctional Psychiatric Hospital, HIV+ and AIDS triple therapy and Hepatitis C treatment. And it is further

ORDERED that within ten (10) calendar days of the entry of this Opinion and Order counsel for the parties shall inform the court in writing of the progress made in organizing the not-for-profit corporation.

IT IS SO ORDERED.

San Juan, Puerto Rico, May 15, 1998.

JUAN M. PEREZ-GIMENEZ

U. S. District Judge

Footnotes

[1] The Court was concerned that the litigation positions of the parties, both of which opposed the expert

witness' recommendations, might not result in a full airing of all the facts and circumstances relevant to its decision in this class action. Accordingly, the court appointed an attorney experienced in institutional reform litigation concerning prisons, John Boston, Esq., the Project Director of the Prisoners' Right Project of the Legal Aid Society of the City of New York (hereinafter "appointed counsel"), to assist in the development of the record at the hearing. Order, July 3, 1997 (Dkt. 5532).

[2] In the order of their presentation these witnesses were:

a. Ernesto Torres Arroyo, M.D., the Medical Director of the Bayamon Correctional Center, is a physician licensed in Puerto Rico and is certified as a specialist in emergency medicine. He testified without objection as an expert in general medicine and in emergency room procedures.

b. Angel Luis Ramos Casanova, M.D., the Medical Director of the Ponce Correctional Complex, is a physician licensed in Puerto Rico and is certified as a specialist in internal medicine. He testified without objection as an expert in internal medicine.

c. Rafael Guzman Fonalledas, M.D., the Medical Director of the Rio Piedras Correctional Complex, is a physician and is certified as an emergency medicine specialist. Because the Executive Director of the CHP had resigned, the Chief Health Care Coordinator had also assigned Dr. Guzman to the main CHP office to assume some responsibilities for all facilities. He testified

without objection as an expert in general medicine and emergenciology.

d. Ana C. Bonet Rolon currently works at the Correctional Health Program as a Resources Consultant for the Chief Health Care Coordinator. She testified without objection as an expert in employment law, particularly in the management of personnel in the health care field, which encompasses correctional health.

e. Jorge Efren Ruiz-Roman, M.D., is Director of the Infectious Control Program for the Correctional Health Program. He testified without objection as an expert in general medicine, infectious disease control, and epidemiology.

f. Lambert N. King, M.D., Ph. D., is the Medical Director/Senior Vice President for Medical and Academic Affairs at St. Vincent's Hospital and Medical Center of New York. He testified without objection as an expert in internal medicine, correctional health care, the administration of health care programs both in public institutions and for profit corporations, and in general health care administration within an institutional setting. His resume shows him to be a distinguished national figure in correctional health care. He has extensive familiarity with this litigation and the prison system of Puerto Rico, having served as plaintiffs' expert since 1979, see *Feliciano v. Barcelo, 497 F. Supp. 14, 21-30 (D.P.R. 1979)* and having been a member of the Joint Health Care Executive Committee and a participant in its 1996 strategic evaluation.

g. Aida Guzman Font, M.D., is the Chief Health Care Coordinator of the Correctional Health Program, and has held that position since 1993. She testified without objection as an expert in health care delivery and psychiatry. Dr. Guzman's acquaintance with this litigation began in 1980, after the court entered a preliminary injunction. At that time she was Assistant Secretary for Mental Health, and she remained involved with prison mental health services until she left that position in 1984. Her lengthy testimony was well informed, precise, knowledgeable, characterized by a thorough knowledge and understanding of present conditions in Puerto Rico's correctional institutions and the structures needed to set up and maintain a health care services delivery system. The testimony of this highly credible and knowledgeable witness carries great weight with the court and suffuses the findings of fact made in this Opinion and Order.

h. Magali Maldonado de Oms, M.D., M.P.H., is the President of Health Insurance and Administrative Services Consultants Corporation. She testified without objection as an expert on the administration of delivery of health care services in public and private sectors and on health care delivery through insurance programs. She has worked with the Chief Health Care Coordinator since October 1996 on issues related to the Correctional Health Program, and both plaintiffs and defendants have relied on her advice in formulating their proposals. Dr. Maldonado de Oms has extensive knowledge of public and

private health care systems and a thorough knowledge of the health care delivery system being implemented at present by the government of Puerto Rico.

i. John Hubert Clark, Jr., M.D., M.P.H., the Chief Medical Officer of the Los Angeles County Sheriff's Department, is a physician licensed in the State of California and the State of Georgia. He testified, over plaintiffs' objection, as an expert in general medicine, correctional health services, and correctional health management administration and accreditation in the private as well as the public sectors. Despite his distinguished resume, Dr. Clark's testimony is entitled to less weight, and is therefore relied upon by the Court only exceptionally: nevertheless in some important respects he agreed with other witnesses.

Based on a weekend's visit to several prisons and a conversation with the CHCC, Dr. Clark had prepared a report, which was made available to counsel. Dr. Shansky and Dr. Aida Guzman reviewed the report and agreed that it was generally superficial and inaccurate; Dr. Shansky: "either misunderstanding of what was going on in the system or an understanding that was extremely superficial and not fully adequate"; Dr. A. Guzman: "not thorough enough ... did not cover all the areas and [...] he lacked the time to go into an in depth evaluation of our system"; See also T434-48, T450-51, T503 for Dr. Shansky's more detailed testimony.

Dr. Clark had concluded that "it is my opinion to a reasonable degree of medical certainty that the inmates incarcerated in the Puerto Rico Department of Corrections are receiving care that meets the minimal standards of the correctional health care profession." However, on cross examination at the hearing after having made a second brief visit to one prison and having listened to and read some of the hearing testimony, he abandoned this conclusion, conceding that "In the total context of the standards, the care is not adequate."

In general, Dr. Clark's testimony added little to the court's understanding. His acquaintance with the prison system was minimal compared with that of other witnesses who testified. Most of his testimony was either peripheral to the significant issues before the court or cumulative of the testimony of other witnesses, for whom he expressed much praise and little disagreement. Moreover, he expressed high regard for the testimony of Drs. Rafael Guzman, Torres, and Ramos, and found nothing in their testimony that he thought was wrong. He agreed that Dr. Aida Guzman, the CHCC, knows her program and stated that her leadership is "second to none." The testimony of these witnesses is far more useful and reliable than is Dr. Clark's.

j. William R. McNeill is an architect who works for Rosser International, a multi-discipline architectural engineering and program management firm that manages the Facilities Renovation Program. His testimony, not as an expert, referred to one of defendants' exhibits,

which is no more than an estimate of costs for the construction and rehabilitation of facilities for the CHP. He also stated that in the past necessary funds have been available when needed.

k. The Hon. Manuel Diaz Saldana was the Secretary of the Treasury of the Government of Puerto Rico, who testified without objection as an expert in financial management, public management, public policy on contracting, government purchasing, and the privatization process from the government standpoint.

l. Ronald M. Shansky, M.D., is a physician licensed in Illinois who is a consultant for corrections medicine and continuous quality improvement, a part-time surveyor for the Joint Commission on Accreditation of Healthcare Organizations, and Attending Physician for the Department of Medicine at Cook County Hospital in Chicago, Illinois. He also serves as court-appointed receiver for medical and mental health at the District of Columbia Jail. He testified without opposition as an expert in general medicine, internal medicine, and prison medical administration. He also has had extensive experience with the Puerto Rico prison system; he worked for the Office of the Court Monitor during 1991-93 and in 1993 was appointed to the Joint Health Care Executive Committee. He returned to Puerto Rico and consulted with the CHCC and other CHP staff and reviewed medical records shortly before the hearing.

m. Vincent M. Nathan, LL. B., the court's expert witness, is an attorney who has served as

special master, monitor, or expert consultant to courts in a number of prison cases. In this litigation, he served from 1986 to 1995 as Court Monitor and from 1995 to 1996 as a joint expert consultant to the parties, and is extensively familiar with the Puerto Rico prison system. He testified without objection as an expert in correctional administration and operations generally as well as monitoring and formulating remedies in prison conditions.

[3] Despite these discouraging findings, the National Commission on Correctional Health Care in 1992 had accredited the medical care programs at four prisons and provisionally accredited four more, with several additional prisons under consideration for accreditation. However, one of the monitor's consultants, Dr. Ronald Shansky, found noncompliance with at least one essential standard at every institution the Commission had accredited. During this investigation, Department of Health personnel provided the monitor's staff with credible evidence that other employees had falsified documents in support of accreditation. Plaintiffs' Exhibit 607, Stipulation Findings of Fact by the Court Monitor Regarding Actions Taken in Advance of NCCHC Accreditation Inspections (June 14, 1993), approved by Order of June 29, 1993, Dkt. 4504. The Executive Director of Correctional Health then withdrew the request for accreditation for all Administration of Correction ("AOC") institutions, including those previously accredited. Office of the Court Monitor, Summary of Morales Feliciano Litigation (January 11, 1995), Dkt. 5532, at 194-95.

[4] "Prevalence" of a disease is the number of patients that have the disease during a given period of time. "Incidence" of a disease denotes the number of patients who become infected with a disease during a given period of time.

[5] Exhibits 331 through 390 highlight the difficulties experienced by the CHP in attempting to obtain an adequate budget over the past four years.

[6] Funds appropriated for the operation of the Correctional Psychiatric Hospital could be used for other purposes because the construction and delivery of the Hospital were inordinately delayed.

[7] Repeatedly, funds promised by the OMB either have never been transferred or a lesser amount than promised has been transferred to AFASS. See Exhibits 373, 375, 377, 380, 381, 383, 385, 386.

[8] Public contracts, once approved, must be numbered. All agencies have a set of numbers for contracts to track them in the system. In effect, the lack of a contract number renders the contract invalid.[9] Another blow to the Program's stability was the transfer of anti addiction functions to the CHP which thus acquired greater obligations without the wherewithal to deliver the services.

[10] Staff classified as "irregular" can, however, begin to accrue sick leave and annual leave after three months of employment, but they do not get medical insurance coverage.

[11] The Court notes that a dispensation can be obtained to hire personnel during the "veda electoral" period (September through December of an electoral year) under emergency conditions or to provide necessary public services. No evidence was presented to show whether or not an application for such a dispensation was made by the Secretary of Health, or why such an application, if made, was denied.

[12] The 14 persons lost by the CHP in 1996 because of Law 150 had not been granted waivers because OCAP determined that the professional services they provided the CHP were the same as those for which permanent employment positions were defined by Puerto Rico's personnel laws. Nevertheless, few positions were available in the CHP for those persons;. For those few permanent positions that did exist, the compensation package established by the DOH could not compete with the compensation available in the private sector.

[13] The Puerto Rico prison system has been receiving acutely psychotic patients from the street over the past few years. From July 1996 to June 1997, 423 acute psychiatric patients with incarceration orders were admitted to the Rio Piedras State Penitentiary. This number represents an increase over prior years. This is also a general problem affecting all intake centers in the AOC system. Admission of these inmates cannot be refused by the AOC because they are committed by Commonwealth courts. When acutely psychotic patients are admitted to an AOC institution, they must be placed in emergency care facilities.

[14] The three main correctional complexes at Rio Piedras, Bayamon and Ponce hold approximately 60% of the AOC's population and must process by far the largest number of admissions to the system: Sabana Hoyos (which is a health care disaster) is smaller and Vega Alta is an intake facility only for women who represent only a small percentage of the total population.

[15] In May 1996, the CHP attempted to purchase new vehicles with funds identified in the program's budget. In spite of the approval by the Chief of Staff, Mr. Angel Morey, to the purchase of new vehicles with funds from the program's 1995-1996 budget, and in spite of the availability of funds from that fiscal year's budget, the Secretary of Health required the program to purchase the vehicles with funds from the 1996-1997 budget, which would have had a detrimental effect on that year's budget. In December 1996, the CHP attempted to consummate the purchase of the vehicles for which the bid had been held the prior fiscal year. The dealer who had won that bid agreed to sell the vehicles to the program at the original 1995 bid prices. AFASS, however, refused to allow the program to purchase vehicles with a 1995 date, and required instead that a new bid be put out, which delayed even further the purchase of the vehicles. In March 1997, the Director of the OMB again forestalled the purchase of the new vehicles which the program had been working on for two years.

[16] In 1993, the CHP contracted with CLENDO Reference Laboratories to provide lab services at Bayamon and Guayama. Because the service provided by CLENDO were satisfactory, the program requested

that AFASS put out a bid request for laboratory services and CLENDO was the successful bidder. In April 1995, CLENDO notified the CHP of the need to renew its contract with CLENDO. The renewed contract was to contain some price changes. AFASS balked at renewing the contract and the CHP attempted to obtain AFASS' assistance in putting out a new bid request, while allowing the program to temporarily renew the contract with CLENDO. The contract was renewed pending resolution of these matters. From 1994 to 1997, however, AFASS carried a substantial debt with CLENDO. The debt eventually reached approximately $ 1,000,000, in spite of numerous attempts by CLENDO to obtain payment for the debt.

The Secretary of Health canceled the CHP's contract with CLENDO Reference Laboratories because she objected to increased prices (which were understood by Program staff to be reasonable) for some services. The Secretary directed, however, that the program could continue to purchase services from CLENDO at open market prices, which resulted in higher overall costs for the program. The Secretary of Health also recommended that the CHP contract for laboratory services through the Medical Services Administration (ASEM, by its Spanishacronym); although ASEM could perform the laboratory services, it could not perform the pick-up and delivery services that CLENDO performed.

[17] The Medical Care Plan requires newly admitted prisoners to be received at a small number of designated "regional intake centers" that provide a full range of necessary medical services. Medical Care Plan at III.A.10. The Plan requires "24 hour per day intake

medical and mental health screening" (Medical Plan at P III.A.10) and requires that screening to be performed "upon [inmates'] arrival." Medical Plan at P III.B.11. A full health assessment is to be conducted within 7 days. Medical Care Plan at III.B.13. At present the regional intake centers are Rio Piedras, Bayamon, Ponce, Sabana Hoyos and Vega Alta.

[18] The dangers of noncompliance with the Plan's admission assessment requirements are illustrated by the case of an inmate with a history of mental health problems who was admitted to Ponce on a motor vehicle violation charge at 10:00 p.m. one night in a state of drug withdrawal. There was no psychologist on duty to evaluate him, in violation of the requirement of "24 hour per day intake medical and mental health screening" to be performed "upon [inmates'] arrival." Medical Plan at PP III.B.10-11. Part of the psychologist's job is to screen new admissions for suicidal tendencies. There was also no room in the infirmary, where this patient would ordinarily have been placed for drug detoxification. He was therefore returned to the intake are, where he committed suicide the next day.

[19] There are a number of patients in the AOC being provided triple therapy. These are limited to those who were receiving the therapy when they were admitted to the system. These prisoners, however, are suffering from the same problems in administration of medication that is experienced throughout the system.

18 USCA § 3626. Appropriate remedies with respect to prison conditions

(a) Requirements for relief.--

(1) Prospective relief.--(A) Prospective relief in any civil action with respect to prison conditions shall extend no further than necessary to correct the violation of the Federal right of a particular plaintiff or plaintiffs. The court shall not grant or approve any prospective relief unless the court finds that such relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right. The court shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the relief.

(B) The court shall not order any prospective relief that requires or permits a government official to exceed his or her authority under State or local law or otherwise violates State or local law, unless--

(i) Federal law requires such relief to be ordered in violation of State or local law;

(ii) the relief is necessary to correct the violation of a Federal right; and

(iii) no other relief will correct the violation of the Federal right.

(C) Nothing in this section shall be construed to authorize the courts, in exercising their remedial powers, to order the construction of prisons or the raising of taxes, or to repeal or detract from otherwise applicable limitations on the remedial powers of the courts.

(2) Preliminary injunctive relief.--In any civil action with respect to prison conditions, to the extent otherwise authorized by law, the court may enter a temporary restraining order or an order for preliminary injunctive relief. Preliminary injunctive relief must be narrowly drawn, extend no further than necessary to correct the harm the court finds requires preliminary relief, and be the least intrusive means necessary to correct that harm. The court shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the preliminary relief and shall respect the principles of comity set out in paragraph (1)(B) in tailoring any preliminary relief. Preliminary injunctive relief shall automatically expire on the date that is 90 days after its entry, unless the court makes the findings required under subsection (a)(1) for the entry of prospective relief and makes the order final before the expiration of the 90-day period.

(3) Prisoner release order.--(A) In any civil action with respect to prison conditions, no court shall enter a prisoner release order unless--

(i) a court has previously entered an order for less intrusive relief that has failed to remedy the deprivation of the Federal right sought to be remedied through the prisoner release order; and

(ii) the defendant has had a reasonable amount of time to comply with the previous court orders.

(B) In any civil action in Federal court with respect to prison conditions, a prisoner release order shall be entered only by a three-judge court in accordance with section 2284 of title 28, if the requirements of subparagraph (E) have been met.

(C) A party seeking a prisoner release order in Federal court shall file with any request for such

relief, a request for a three-judge court and materials sufficient to demonstrate that the requirements of subparagraph (A) have been met.

(D) If the requirements under subparagraph (A) have been met, a Federal judge before whom a civil action with respect to prison conditions is pending who believes that a prison release order should be considered may sua sponte request the convening of a three-judge court to determine whether a prisoner release order should be entered.

(E) The three-judge court shall enter a prisoner release order only if the court finds by clear and convincing evidence that--

(i) crowding is the primary cause of the violation of a Federal right; and

(ii) no other relief will remedy the violation of the Federal right.

(F) Any State or local official including a legislator or unit of government whose jurisdiction or function includes the appropriation of funds for the construction, operation, or maintenance of prison facilities, or the prosecution or custody of persons who may be released from, or not admitted to, a prison as a result of a prisoner release order shall have standing to oppose the imposition or continuation in effect of such relief and to seek termination of such relief, and shall have the right to intervene in any proceeding relating to such relief.

(b) Termination of relief.--

(1) Termination of prospective relief.--(A) In any civil action with respect to prison conditions in which prospective relief is ordered, such relief shall be terminable upon the motion of any party or

intervener--

(i) 2 years after the date the court granted or approved the prospective relief;

(ii) 1 year after the date the court has entered an order denying termination of prospective relief under this paragraph; or

(iii) in the case of an order issued on or before the date of enactment of the Prison Litigation Reform Act, 2 years after such date of enactment.

(B) Nothing in this section shall prevent the parties from agreeing to terminate or modify relief before the relief is terminated under subparagraph (A).

(2) Immediate termination of prospective relief.--In any civil action with respect to prison conditions, a defendant or intervener shall be entitled to the immediate termination of any prospective relief if the relief was approved or granted in the absence of a finding by the court that the relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right.

(3) Limitation.--Prospective relief shall not terminate if the court makes written findings based on the record that prospective relief remains necessary to correct a current and ongoing violation of the Federal right, extends no further than necessary to correct the violation of the Federal right, and that the prospective relief is narrowly drawn and the least intrusive means to correct the violation.

(4) Termination or modification of relief.--Nothing in this section shall prevent any party or intervener from seeking modification or termination before the relief is terminable under paragraph (1) or (2), to the extent that modification or termination would

otherwise be legally permissible.

(c) Settlements.--

(1) Consent decrees.--In any civil action with respect to prison conditions, the court shall not enter or approve a consent decree unless it complies with the limitations on relief set forth in subsection (a).

(2) Private settlement agreements.--(A) Nothing in this section shall preclude parties from entering into a private settlement agreement that does not comply with the limitations on relief set forth in subsection (a), if the terms of that agreement are not subject to court enforcement other than the reinstatement of the civil proceeding that the agreement settled.

(B) Nothing in this section shall preclude any party claiming that a private settlement agreement has been breached from seeking in State court any remedy available under State law.

(d) State law remedies.--The limitations on remedies in this section shall not apply to relief entered by a State court based solely upon claims arising under State law.

(e) Procedure for motions affecting prospective relief.--

(1) Generally.--The court shall promptly rule on any motion to modify or terminate prospective relief in a civil action with respect to prison conditions. Mandamus shall lie to remedy any failure to issue a prompt ruling on such a motion.

(2) Automatic stay.--Any motion to modify or terminate prospective relief made under subsection (b) shall operate as a stay during the period—

(A)(i) beginning on the 30th day after such motion is filed, in the case of a motion made under paragraph (1) or (2) of subsection (b); or

(ii) beginning on the 180th day after such motion is filed, in the case of a motion made under any other law; and

(B) ending on the date the court enters a final order ruling on the motion.

(3) Postponement of automatic stay.--The court may postpone the effective date of an automatic stay specified in subsection (e)(2)(A) for not more than 60 days for good cause. No postponement shall be permissible because of general congestion of the court's calendar.

(4) Order blocking the automatic stay.--Any order staying, suspending, delaying, or barring the operation of the automatic stay described in paragraph (2) (other than an order to postpone the effective date of the automatic stay under paragraph (3)) shall be treated as an order refusing to dissolve or modify an injunction and shall be appealable pursuant to section 1292(a)(1) of title 28, United States Code, regardless of how the order is styled or whether the order is termed a preliminary or a final ruling.

(f) Special masters.--

(1) In general.--(A) In any civil action in a Federal court with respect to prison conditions, the court may appoint a special master who shall be disinterested and objective and who will give due regard to the public safety, to conduct hearings on the record and prepare proposed findings of fact.

(B) The court shall appoint a special master under this subsection during the remedial phase of the action

only upon a finding that the remedial phase will be sufficiently complex to warrant the appointment.

(2) Appointment.--(A) If the court determines that the appointment of a special master is necessary, the court shall request that the defendant institution and the plaintiff each submit a list of not more than 5 persons to serve as a special master.

(B) Each party shall have the opportunity to remove up to 3 persons from the opposing party's list.

(C) The court shall select the master from the persons remaining on the list after the operation of subparagraph (B).

(3) Interlocutory appeal.--Any party shall have the right to an interlocutory appeal of the judge's selection of the special master under this subsection, on the ground of partiality.

(4) Compensation.--The compensation to be allowed to a special master under this section shall be based on an hourly rate not greater than the hourly rate established under section 3006A for payment of court-appointed counsel, plus costs reasonably incurred by the special master. Such compensation and costs shall be paid with funds appropriated to the Judiciary.

(5) Regular review of appointment.--In any civil action with respect to prison conditions in which a special master is appointed under this subsection, the court shall review the appointment of the special master every 6 months to determine whether the services of the special master continue to be required under paragraph (1). In no event shall the appointment of a special master extend beyond the termination of the relief.

(6) Limitations on powers and duties.--A special master appointed under this subsection--

(A) may be authorized by a court to conduct

hearings and prepare proposed findings of fact, which shall be made on the record;
(B) shall not make any findings or communications ex parte;
(C) may be authorized by a court to assist in the development of remedial plans; and
(D) may be removed at any time, but shall be relieved of the appointment upon the termination of relief.

(g) Definitions.--As used in this section--

(1) the term "consent decree" means any relief entered by the court that is based in whole or in part upon the consent or acquiescence of the parties but does not include private settlements;
(2) the term "civil action with respect to prison conditions" means any civil proceeding arising under Federal law with respect to the conditions of confinement or the effects of actions by government officials on the lives of persons confined in prison, but does not include habeas corpus proceedings challenging the fact or duration of confinement in prison;
(3) the term "prisoner" means any person subject to incarceration, detention, or admission to any facility who is accused of, convicted of, sentenced for, or adjudicated delinquent for, violations of criminal law or the terms and conditions of parole, probation, pretrial release, or diversionary program;
(4) the term "prisoner release order" includes any order, including a temporary restraining order or preliminary injunctive relief, that has the purpose or effect of reducing or limiting the prison population, or that directs the release from or nonadmission of

prisoners to a prison;

(5) the term "prison" means any Federal, State, or local facility that incarcerates or detains juveniles or adults accused of, convicted of, sentenced for, or adjudicated delinquent for, violations of criminal law;

(6) the term "private settlement agreement" means an agreement entered into among the parties that is not subject to judicial enforcement other than the reinstatement of the civil proceeding that the agreement settled;

(7) the term "prospective relief" means all relief other than compensatory monetary damages;

(8) the term "special master" means any person appointed by a Federal court pursuant to Rule 53 of the Federal Rules of Civil Procedure or pursuant to any inherent power of the court to exercise the powers of a master, regardless of the title or description given by the court; and

(9) the term "relief" means all relief in any form that may be granted or approved by the court, and includes consent decrees but does not include private settlement agreements.

d States.

No. 01-2201

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

CARLOS MORALES FELICIANO ET AL.,
Plaintiffs, Appellees,
v.
JOHN RULLAN, SECRETARY OF THE PUERTO RICO DEPARTMENT OF HEALTH, ETC.,
Defendant, Appellant.

July 15, 2002, Decided

COUNSEL: Carlos Del Valle, with whom Anabelle Rodriguez, Attorney General, Eileen Landron Guardiola, and Eduardo A. Vera Ramirez were on brief, for appellant.

Alejandra Bird Lopez, with whom Carlos V. Garcia Gutierrez, Manuel Rodriguez Banchs, Rafael E. Rodrigues Rivera, and Civil Action and Education Corporation were on brief, for appellees.

JUDGES: Before Boudin, Chief Judge, Bownes, Senior Circuit Judge, and Selya, Circuit Judge.

OPINION BY: SELYA

OPINION:

SELYA, Circuit Judge. This interlocutory appeal requires us to revisit a marathon class-action suit brought to remedy unconstitutional conditions of confinement in the Puerto Rico prison system. On this

occasion, the Secretary of the Puerto Rico Department of Health (the Secretary) alleges that the district court's assignment of certain duties to the so-called chief health care coordinator (the CHCC) constitutes an unwarranted modification of a prior injunction and, in the bargain, violates the Prisoner Litigation Reform Act of 1995 (PLRA), Pub. L. No. 104-134, 110 Stat. 1321 (1996) (codified as amended in scattered sections of 18 U.S.C., 28 U.S.C., & 42 U.S.C.). The plaintiff class (composed of prison inmates) responds that this court lacks jurisdiction to consider the appeal on an interlocutory basis, and that, in all events, the challenged order is a proper exercise of the district court's authority. We agree with the first of the plaintiffs' assertions: the challenged order merely clarifies the court's prior decrees and imposes no serious consequences on the Secretary. Moreover, the order, in the last analysis, is a procedural measure that constitutes an exercise of the district court's housekeeping powers. For these reasons, immediate appellate review is not available to the Secretary as of right. Consequently, we dismiss the appeal without addressing the remaining issues briefed and argued by the parties.

I. BACKGROUND

Although the lore of this case is Byzantine, we confine our introductory remarks to those events that are directly pertinent to this appeal. We refer readers who hunger for more exegetic detail to the district court's myriad opinions. E.g., *Morales Feliciano v. Rosello Gonzalez*, 13 F. Supp. 2d 151 (D.P.R. 1998) (Morales II); *Morales Feliciano v. Romero Barcelo*, 497 F. Supp. 14 (D.P.R. 1979) (Morales I)

In early 1979, representatives of the plaintiff class commenced this action under 42 U.S.C. § 1983. They named several public officials as defendants, including, pertinently, the Secretary. The suit alleged dire shortcomings in virtually every aspect of prisoner confinement. The district court found that the plaintiffs were likely to succeed on some of their claims and issued a preliminary injunction ordering the defendants to address the most pressing of the identified concerns. See Morales I, 497 F. Supp. at 38-41. The court gave very high priority to inadequate medical and mental health care. See id. at 37-38.

Over time, the district court grew frustrated with the defendants' desultory responses to the preliminary injunction. To expedite compliance, the court appointed a monitor in March of 1986. The court charged the monitor with studying the relevant elements of the corrections program and recommending remedial action. With the monitor in place, the court became actively involved in certain aspects of the management of the prison system. Not surprisingly, the court found inertia to be a persistent problem and, to overcome it, issued temporary restraining orders and contempt citations against the defendants when and as required. The court also began to impose fines for the defendants' most egregious failures to comply with its decrees (particularly those failures relating to overcrowding). Those fines escalated as the foot-dragging continued and the court's level of exasperation mounted. To date, the court has levied aggregate fines totaling nearly $ 135,000,000.

In October of 1990, the court ordered the implementation of medical and mental health care plans

(the Plans) recommended by the monitor. By their terms, the Plans contemplated that overall responsibility for inmate health care would pass from the Administration of Corrections to the Department of Health. The Plans also required the Secretary to employ, for at least three years, a designated official -- the CHCC -- who would be responsible for easing the transition and coordinating compliance with the Plans.[1] In April of 1993, the Secretary nominated Dr. Aida Guzman Font to assume the position. The district court approved financial support (from the fine fund) for her endeavors. When her term expired three years later, the parties jointly requested that the court approve her reappointment. The court obliged.

In January of 1996, the district court entered what it termed a "partial final judgment." In this decree, the court settled several disputed issues and urged the parties to focus their energies on "consensus-based compliance efforts, and the resolution of yet unresolved areas of the case." In the same document, the court enumerated certain prior orders that it now considered final (including the order approving the Plans and the orders containing the job description for the CHCC position).

The passage of time revealed that the remedial framework was not functioning smoothly. In April of 1997, a court-appointed expert found that the extant correctional health program was a bureaucratic morass incapable of meeting constitutional standards. To rectify this situation, the expert suggested the appointment of a receiver for the ailing program. The parties closed ranks to oppose this recommendation, proposing instead the creation of a private non-profit

corporation (the Corporation), which would eventually assume total responsibility for providing medical and mental health services to the inmate population.

On September 26, 1997, the parties filed a stipulation designed to flesh out this joint proposal. Under its terms, the Corporation would provide health care services, consistent with the Plans, to all persons held in institutions operated by the Administration of Corrections. The stipulation promised "full coordination among all parties concerned" and required the defendants (including the Secretary) to take a series of preparatory steps to lay the groundwork for an effective transition from the existing correctional health program to the new model. The stipulation also memorialized the parties' agreement to engage in further discussions "concerning the role and authority of the CHCC with respect to monitoring the Corporation." Finally, the process of privatization -- that is, the transition from the existing remedial framework to the stipulated alternative -- was made subject to the district court's supervision. The court would be kept informed by, inter alia, the submission of regular progress reports from the CHCC.

In an ensuing opinion, the district court elaborated on the constitutional deficiencies of the existing health care programs, but declined to rule on the receivership recommendation. *Morales* II, 13 F. Supp. 2d at 213. Instead, the court issued a series of orders designed to "build on the remedial structure . . . already in place." Id. In so doing, the court reaffirmed its earlier support for the Plans and expressed a willingness to listen should the parties or the CHCC "request modifications of the [Plans] to keep abreast of health care

developments or to enhance administrative and fiscal efficiency." Id. at 158.

The court also acknowledged the recommendation for the creation of a private non-profit corporation as a vehicle for the delivery of inmate health care services. See id. at 203 (citing the testimony of an expert in correctional health care to the effect that "the objective of an adequate budget process and a sense of relative permanency can be accomplished through a private not-for-profit health care corporation whose primary mission is correctional health care"). But the court expressed skepticism about the parties' abilities to establish such an entity and ordered class counsel to report within ten days on the progress made in organizing the Corporation. Id. at 214. Within the allotted period, class counsel outlined the steps that were being taken to create the Corporation.

Although Morales II provides, at best, a tentative endorsement of the parties' suggested remedy, the court's subsequent statements and actions indicate full support for the nascent Corporation. That support has been unwavering: despite slower-than-expected progress on the path to privatization, the court has regularly reviewed and approved annual budgets for the Corporation and has authorized the disbursement of substantial monies from the fine fund to cover the Corporation's operating expenses. To date, these disbursements total around $ 20,000,000.

On March 31, 2000, Dr. Guzman resigned. The district court believed that recruiting a new CHCC would be inopportune given the Corporation's "advanced stage of development" and the court's expectation that the

Corporation would take over the delivery of correctional health care services within the next eighteen months. Still, the vacancy left a void. To bridge the gap temporarily, the court entered an order transferring some of the CHCC's duties to the executive director of the correctional health program (Dr. Ernesto Torres Arroyo).

A new administration came to power in Puerto Rico following the November 2000 general elections. The following February, the Secretary -- an appointee of the newly-elected governor -- sought to terminate Dr. Torres' employment as executive director of the correctional health program. In response to the plaintiffs' objection, the district court restrained the Secretary from cashiering Dr. Torres until such time as the court chose to relieve him of the duties assigned to him after Dr. Guzman's resignation.

The Secretary did not appeal from this order, but, rather, notified the court that he was reappointing Dr. Guzman to the vacant CHCC position. In the same motion, he asked the court to approve the appointment. The court ordered the parties to confer and submit a joint proposal designed to harmonize the CHCC's job description with the court's prior orders. The parties were unable to reach agreement. The principal bone of contention centered on the extent to which the Secretary (and, to some degree, the CHCC) would be in control of decisions regarding the privatization process.

The district court resolved the matter by issuing the order underlying the instant appeal. That ukase, entered on May 23, 2001, noted that the court had "ordered, as a solution to the myriad of problems

affecting delivery of mental and medical health services to the plaintiff class in this case, the creation and organization of a private, not-for-profit corporation, to replace the present Correctional Health Program." This made it "imperative that the [CHCC] cooperate[] fully with the [Corporation] during the transition period." To achieve this goal, the court directed the CHCC to (1) provide the Corporation with information reasonably necessary for the performance of its obligations; (2) ensure attendance of correctional health program workers at training seminars organized by the Corporation; (3) appoint coordinators to assist in the development of the training seminars, the reorganization of work areas, and the installation of electronic and telephonic equipment in the medical areas of correctional institutions; (4) guard against the improper use of installed equipment; (5) require the presence of Corporation personnel during consultations with higher officials anent matters related to the provision of correctional health services; (6) inform the Corporation's chief executive officer (CEO) of the times and locations of certain meetings; and (7) attend relevant meetings called by the Corporation's board or its CEO.

The Secretary chafed at this directive and asked the district court to reconsider it. He argued, inter alia, that the order was superfluous because the CHCC, of her own volition, was cooperating fully with the Corporation. The plaintiff class opposed reconsideration, claiming that there was ample reason to believe that the Secretary and the CHCC were refusing to cede control over the provision of inmate health services while simultaneously conspiring to appropriate the Corporation's resources. When the

district court denied reconsideration, the Secretary appealed.

On appeal, the Secretary asseverates that the assignment of new duties to the CHCC contravenes the district court's January 1996 partial judgment, which purported to make final several earlier orders (including the orders that collectively contained the CHCC's job description). Building on that foundation, the Secretary posits that the district court lacked jurisdiction to modify the January 1996 judgment and, alternatively, that the May 23 order fails to comport with the requirements of the PLRA. The plaintiffs counter that this interlocutory appeal must be dismissed for lack of jurisdiction; and that, in all events, the May 23 order is unimpugnable.

II. APPELLATE JURISDICTION

It is black-letter law that "federal courts are courts of limited jurisdiction, and thus must take pains to act only within the margins of that jurisdiction." *Cumberland Farms, Inc. v. Me. Tax Assessor*, 116 F.3d 943, 945 (1st Cir. 1997). Hence, the preferred -- and often the obligatory -- practice is that a court, when confronted with a colorable challenge to its subject-matter jurisdiction, should resolve that question before weighing the merits of a pending action. See *Berner v. Delahanty*, 129 F.3d 20, 23 (1st Cir. 1997); see also *Steel Co. v. Citizens for a Better Environment*, 523 U.S. 83, 94, 140 L. Ed. 2d 210, 118 S. Ct. 1003 (1998). This principle holds true when an appellate court's right to exercise appellate jurisdiction is called into question. *In re Cusumano*, 162 F.3d 708, 712 (1st Cir. 1998); *Director, OWCP v. Bath Iron Works Corp.*, 853 F.2d 11,

12-13 (1st Cir. 1988). Thus, we turn first to the question of our own jurisdiction. We start this inquiry by elucidating the general tenets that govern the existence of appellate jurisdiction and then proceed to apply those tenets to the case at hand.

A. The Legal Landscape.

There is a well-established legislative policy disfavoring inchmeal appellate review. See *Anderson v. City of Boston*, 244 F.3d 236, 238 (1st Cir. 2001). This policy makes very good sense. "Multiple appeals in a single litigation are necessarily disruptive and, if freely allowed, subject to abuse." *Sierra Club v. Marsh*, 907 F.2d 210, 214 (1st Cir. 1990). Thus, a federal court of appeals, as a general rule, will review decisions made by a district court only after that court enters a final judgment. See 28 U.S.C. § 1291.

This rule, like virtually every general rule, admits of certain exceptions. One exception to the rule against interlocutory appeals is embedded in 28 U.S.C. § 1292(a)(1). That statute authorizes immediate review of district court orders "granting, continuing, modifying, refusing or dissolving injunctions, or refusing to dissolve or modify injunctions." Id. This exception must be strictly construed. *Sierra Club*, 907 F.2d at 214. Strict construction prevents the statute from being used as a means of evading the final judgment rule.

To determine whether a particular trial court order is appealable under section 1292(a)(1), a reviewing court must look to the practical effect of the order rather than its verbiage. See *Carson v. American Brands, Inc.*, 450 U.S. 79, 84, 67 L. Ed. 2d 59, 101 S. Ct. 993 (1981). The

Carson Court also made plain that a party seeking the benefit of section 1292(a)(1) must establish that the contested order imposes "serious, perhaps irreparable, consequences" and that it may be challenged effectively only by immediate appeal. Id.

Another line of cases has relevance here. Although orders that modify injunctions may be appealable under section 1292(a)(1), orders that merely clarify previously entered injunctions are not. See, e.g., *Birmingham Fire Fighters Ass'n 117 v. Jefferson County*, 280 F.3d 1289, 1292-93 (11th Cir. 2002); *United States Fire Ins. Co. v. Asbestospray, Inc.*, 182 F.3d 201, 207 (7th Cir. 1999); *Mikel v. Gourley*, 951 F.2d 166, 168 (8th Cir. 1991). To ascertain whether an order modifies an injunction, we must determine whether the underlying decree is of an injunctive character, and if so, whether the ruling complained of can be said to have altered the underlying decree in a jurisdictionally significant way. *Sierra Club*, 907 F.2d at 212. A change is jurisdictionally significant if it substantially readjusts the legal relations of the parties, see *Cunningham v. David Special Commitment Ctr.*, 158 F.3d 1035, 1037 (9th Cir. 1998), and does not relate simply to the conduct or progress of litigation, see *Gulfstream Aerospace Corp. v. Mayacamas Corp.*, 485 U.S. 271, 279, 99 L. Ed. 2d 296, 108 S. Ct. 1133 (1988). Doubts as to the applicability of section 1292(a)(1) are to be resolved against immediate appealability.

B. The Case at Hand.

Here, the Secretary appeals from the district court's order of May 23, 2001, claiming that it modifies a previously issued injunction. He maintains that the

underlying injunctive decree -- the decree modified by the order appealed from -- is the January 1996 partial final judgment. This designation strikes us as arbitrary. The district court created the CHCC position in an order dated October 22, 1990; broadened its purview somewhat by order dated December 18, 1992; and continued the office in effect without any appreciable change in the 1996 partial final judgment. By the same token, the court issued several orders affecting the CHCC position in the period between January of 1996 and May of 2001.[2] Last -- but far from least -- the district court did not refer at all to the 1996 partial final judgment in crafting the order of May 23, 2001. Given this history, the Secretary's designation of the 1996 partial final judgment as the underlying injunction seems odd. The most that can be said is that the combination of orders composing the status quo as of May 23, 2001 amounted to an injunction.

Leaving to one side this obvious weakness in the Secretary's case, the question remains whether the May 23 order represented a jurisdictionally significant change in the status quo. See *Sierra Club*, 907 F.2d at 212-13. Answering this question requires us to focus on the practical effect of the order. See *id.* at 213.

As a practical matter, the May 23 order did not break new ground. The stipulation entered into by and between the parties on September 26, 1997 heralded the dawning of a new era, paving the way for a phase-out of the preexisting correctional health program and the creation of the Corporation as a new and different way to provide health services to inmates. That stipulation itself imposed obligations on the CHCC to report on the progress, and otherwise monitor the

activities, of the new Corporation. While these changes constituted a dramatic modification of the status quo ante, the Secretary certainly cannot complain about them; they were introduced with the consent and active cooperation of his predecessor in office and, thus, bind the Secretary now. See *Cornelius v. Hogan*, 663 F.2d 330, 334-35 (1st Cir. 1981) (finding, in an official-capacity suit, that a successor in office was bound by his predecessor's consent decree); see also Fed. R. Civ. P. 25(d)(1). A party's stipulations are binding on that party and may not be contradicted by him at trial or on appeal. *Keller v. United States*, 58 F.3d 1194, 1199 n.8 (7th Cir. 1995). It follows from these two propositions that a government official, sued in his representative capacity, cannot freely repudiate stipulations entered into by his predecessor in office during an earlier stage of the same litigation.

The Secretary tries to wiggle off this hook by arguing that we should disregard the stipulation because it was not explicitly entered by the district court. This argument borders on the jejune. The parties docketed the stipulation and, although the district court did not instantly embrace it, the court's subsequent actions -- particularly the entry of orders designed to facilitate the establishment of the new remedial framework and the release of funds to finance those activities -- made manifest the court's adoption of the concept. In all events, the court certainly believed that it had approved the stipulation and its serial orders put the Secretary on clear notice of its belief. See, e.g., Order of July 2, 1998 (reminding the parties that "correctional health services would soon begin to undergo the transition to a private non-profit corporation"); Order of April 19, 2000 (stating that the court previously had

"accepted and ordered the implementation of the parties' stipulations and proposals to create a not-for-profit Correctional Health Services Corporation"). If the Secretary wished to hold the district court to a particular punctilio in the entry of the stipulation, the Secretary had an obligation to assert that position in a timely manner. See *Putnam Resources v. Pateman*, 958 F.2d 448, 456-57 (1st Cir. 1992) (explaining that an aggrieved party ust act expeditiously to cure perceived error); see generally *United States v. Taylor*, 54 F.3d 967, 972 (1st Cir. 1995) (stating that "a litigant who deems himself aggrieved" by a ruling of the trial judge "ordinarily must object then and there, or forfeit any right to complain at a latter time"). His failure to do so constitutes a waiver.

Against this backdrop, it is surpassingly difficult to see how the May 23 order worked a jurisdictionally significant change in the status quo. In some respects, this case is reminiscent of *Gautreaux v. Chicago Housing Authority*, 178 F.3d 951 (7th Cir. 1999). There, the Seventh Circuit held that an order directing a housing authority to involve a receiver in any settlement negotiations with tenants of a particular housing project was merely a reiteration of an earlier receivership decree that required "full cooperation" with the receiver. *Id.* at 953. On that basis, the court deemed the order unappealable under section 1292(a)(1). *Id.* at 958.

This case is similarly configured. The stipulation obligated the parties, in effect, to cooperate fully in the privatization process. The assignment of specific duties to the CHCC -- the part of the May 23 order that rankles the Secretary -- is simply another way of

expressing what is reasonably to be expected from the stipulated promise of full cooperation. In short, the May 23 order is a logical corollary to the Secretary's stipulated commitment to assist in the privatization of the delivery of correctional health services.[3]

The particulars of the May 23 order do not alter this analysis. The specific dictates contained in that order -- for instance, those requiring consultation with Corporation personnel and support of training programs -- do no more than identify particular areas in which cooperation is required. Thus, the enumerated duties, taken as a whole, do not modify the status quo in any meaningful way. Confirming this conclusion is the fact that the Secretary initially objected to the May 23 order on the ground that it added nothing new to what the CHCC already was doing. His belated attempt to press the opposite view in this venue is untenable. Cf. *Lydon v. Boston Sand & Gravel Co.*, 175 F.3d 6, 12 (1st Cir. 1999) (warning that "if parties feel free to select contradictory positions before different tribunals to suit their ends, the integrity and efficacy of the courts will suffer") (quoting *Patriot Cinemas, Inc. v. Gen. Cinema Corp.*, 834 F.2d 208, 214 (1st Cir. 1987)).

For much the same reasons, we do not accept the Secretary's plaint that the May 23 order has serious consequences. The order is disruptive, he tells us, because it undermines his authority to control the actions of a subordinate and, concomitantly, forces that subordinate -- the CHCC -- to preside over the dismantling of the correctional health program. This tale is unconvincing -- and mischaracterizes the record to boot.

In the first place, it was the Secretary -- not the district court -- who insisted on filling the CHCC position. He nominated Dr. Guzman for the post knowing full well that a court- ordered privatization of health care services was in full swing. He cannot seriously contend that his unilateral decision to fill this vacancy somehow wipes the slate clean, allowing him to throw a monkey wrench into the privatization process and scuttle the reforms to which his predecessor had stipulated.

In the second place, the consequences that the Secretary cites are the natural sequelae of the earlier agreement to transfer correctional health services to the Corporation. Those woes are not fairly attributable to the May 23 order. By first consenting to the privatization plan and then seeking to fill the CHCC position while the transition to privatization was underway, the Secretary became the author of his own misfortune.

If more were needed on this point -- and we doubt that it is -- the Secretary's argument misstates the nature of the CHCC position. That position has never been exclusively under the Secretary's hegemony. From the very beginning, the CHCC has been subject to dual oversight, reporting both to the Secretary and the district court.[4] This dual reporting relationship dovetails with the remedial framework that the court erected when it created the CHCC position to address constitutional shortcomings in inmate health services. Given the hybrid nature of the position, fine- tuning the CHCC's role to accommodate the stipulated changeover to privatization does little to alter the legal relations of the parties as they existed on May 23, 2001. The

alteration, as we have said, dates back to the execution of the stipulation.

There is yet another basis for our conclusion that the May 23 order does not significantly modify the status quo. The parties, through the stipulation, explicitly agreed that "the privatization process must be subject to Court supervision." This language gave the court substantial latitude in procedural matters relating to how best to achieve privatization. Given that fostering compliance with the district court's remedial framework is the CHCC's raison etre, the order that the Secretary challenges here can be viewed as procedural in nature (akin, say, to the appointment of a monitor).

The Ninth Circuit dealt with an analogous procedural order in *Thompson v. Enomoto*, 815 F.2d 1323 (9th Cir. 1987), a prisoner class action. There, the court had to decide whether the appointment of a special master to supervise compliance with a consent decree constituted a modification of the decree. Emphasizing the interim nature of the position, the court found no "serious or irreparable harm" stemming from the appointment. *Id.* at 1327. We think that here, as in Thompson, the order appealed from was within the lower court's reserved power to establish procedures for compliance with the court's earlier decrees.[5] Id. So viewed, the May 23 order was simply "a step in controlling the litigation before the court," *Baltimore Contractors, Inc. v. Bodinger*, 348 U.S. 176, 185, 99 L. Ed. 233, 75 S. Ct. 249 (1955). Orders of that stripe are not immediately appealable. See, e.g., *Van Orman v. Am. Ins. Co.*, 680 F.2d 301, 314 (3d Cir. 1982) (dismissing interlocutory appeal when the order appealed from was merely a "judicial

housekeeping measure designed to assist the court in framing ultimate relief in the case").

III. CONCLUSION

To recapitulate, the May 23 order is not a modification of a previous injunction, but, rather, a clarification of the CHCC's role in light of other developments in the case. At any rate, the order does not have serious or irreparable consequences for the Secretary because any infringement on his autonomy is a function of previously ordered relief. Finally, the nature of the obligations imposed on the CHCC places the May 23 order in the category of procedural orders that are not immediately appealable.

We need go no further. For the reasons discussed above, we dismiss the appeal for want of appellate jurisdiction.

Appeal dismissed.

- - - - - - - - - - - - - Footnotes - - - - - - - - - - - - -

n1 The designated official initially was called the "chief medical coordinator." The title was changed in December of 1992.

n2 These include an order of May 16, 1997 (directing the CHCC to take contractual steps to maintain continuity of health services) and an order of April 19, 2000 (declining to name a new CHCC because the position would become obsolete within "a brief period of time").

n3 This conclusion is fortified by the fact that the CHCC position was created for the express purpose of

implementing the Plans. The parties (through the stipulation) and the district court have now determined that privatization is the best route to achieve that goal. From that standpoint, a failure on the part of the CHCC to assist in executing the privatization process would violate her longstanding duty to implement the Plans.

n4 The process by which the Secretary aspired to reappoint Dr. Guzman as the CHCC illustrates this dichotomy. Although the Secretary selected her for the position, he submitted the nomination to the district court for the court's approval.

n5 As was true of the court-appointed special master in Thompson, the CHCC position was never meant to exist in perpetuity. To the contrary, the Plans contemplate that the CHCC will serve a three-year term, and the court has made it abundantly clear that the position will become obsolete once the transition to privatization has been completed. Thus, the May 23 order is temporary in the sense that it applies only to the transition period.

The Eighth Amendment of the Constitution:

Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted.

The Eleventh Amendment of the Constitution:

The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State.

The controlling portion of the Fourteenth Amendment of the Constitution reads as follows:

Sect. 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law, which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

§ 1983. Civil action for deprivation of rights

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities

secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

The Prisoner Litigation Reform Act ("PLRA"), Pub.L. No. 104-134, 110 Stat. 1321 (1996) (codified as amended in scattered sections of 18 U.S.C., 28 U.S.C., & 42 U.S.C.), is set forth in full in Appendix, at _____.

The relevant provision for jurisdiction of the district court below is 28 U.S.C.S. § 1343 (3) (2001)

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§1343. Civil rights and elective franchise

(a) The district courts shall have original jurisdiction of any civil action authorized by law to be commenced by any person:

(1) To recover damages for injury to his person or property, or because of the deprivation of any right or privilege of a citizen of the United States, by any act done in furtherance of any conspiracy mentioned in section 1985 of Title 42; **(2)** To recover damages from any person who fails to prevent or to aid in preventing any wrongs mentioned in section 1985 of Title 42, which he had, knowledge were about to occur and power to prevent; **(3)** To redress the deprivation,

under color of any State law, statute, ordinance, regulation, custom or usage, of any right, privilege or immunity secured by the Constitution of the United States or by any Act of Congress providing for equal rights of citizens or of all persons within the jurisdiction of the United States; (4) To recover damages or to secure equitable or other relief under any Act of Congress providing for the protection of civil rights, including the right to vote.

The relevant provision for the appellate jurisdiction of the court below:

§ 1292. Interlocutory decisions

(a) Except as provided in subsections (c) and (d) of this section, the courts of appeals shall have jurisdiction of appeals from:

(1) Interlocutory orders of the district courts of the United States, the United States District Court for the District of the Canal Zone, the District Court of Guam, and the District Court of the Virgin Islands, or of the judges thereof, granting, continuing, modifying, refusing or dissolving injunctions, or refusing to dissolve or modify injunctions, except where a direct review may be had in the Supreme Court;

The provision for jurisdiction of this court is

Rule 10. Considerations Governing Review on Certiorari

Review on a writ of certiorari is not a matter of right, but of judicial discretion. A petition for a writ of

certiorari will be granted only for compelling reasons. The following, although neither controlling nor fully measuring the Court's discretion, indicate the character of the reasons the Court considers:

(a) A United States court of appeals has entered a decision in conflict with another United States court of appeals on the same important matter; has decided an important federal question in a way that conflicts with a decision by a state court of last resort; or has so far departed from the accepted and usual course of judicial proceedings, or sanctioned such a departure by a lower court, as to call for an exercise of this Court's supervisory power;....